LONGMONT BRACES

Welcome to Longmont Braces!
Please fill out this form completely. Thank you!

About You

Today's Date_____

Name_____ Preferred Name/Nickname_____
Street Address_____
City_____ State _____ Zip _____Home Phone_____
Birth Date____/____/____ Age_____ Sex ☐M ☐F Employer_____
Day-Time Phone _____Cell Phone _____E-mail address _____Spouse's Name_____
How did you hear about our office? _____
What is the reason you are seeking an orthodontic evaluation? _____
Has an orthodontist been consulted previously? ☐ Yes☐ No Reason: _____
Please list other family members seen in our office and their relation to you: _____

Medical Health Information

Have you been hospitalized for any surgical procedure or serious illness?☐ Yes☐ No
Name of your physician_____
Address_____Phone_____
Do you have or have you had any of the following diseases or conditions? (Check all that apply.)_____

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Fainting Spells. Seizures	☐	☐	AIDS, HIV Positive
☐	☐	Stroke	☐	☐	Scarlet Fever, Rheumatic Heart Disease	☐	☐	Herpes, Fever Blisters
☐	☐	Asthma	☐	☐	Allergies (medicine or other)	☐	☐	Joint Replacement or Implant
☐	☐	Hepatitis	☐	☐	Latex or Nickel Sensitivity/Allergy	☐	☐	Excessive Bleeding or Bruising
☐	☐	Pregnancy	☐	☐	High or Low Blood Pressure	☐	☐	Drug or Alcohol Dependency
☐	☐	Heart Defect, Heart Murmur, Heart Disease				☐	☐	Tonsils or Adenoids Removed

Do you or have you ever taken bisphosphonates, including Fosomax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa?_____
If so, which drug?_____
Do you have any disease, condition, or problem not listed that you think we should know about? Please Explain:
_____
Are you taking any medication at this time? ☐ Yes ☐ No If yes, Please list_____

Dental Insurance Information

Primary Insurance Company Name_____

Do you participate in a flex plan? ☐ Yes ☐ No

Dental Health Information

Are you experiencing any Dental Problems☐ Yes ☐ No Date of last dental visit___/___/____
How often do you brush and floss each day? Brush ___ times per day Floss ___ times per day
Dentist: _____
Do you have or have you ever had any of the following problems?

Yes	No		Yes	No		Yes	No	
☐	☐	Tongue Thrust	☐	☐	Jaw Pain (Joint, Ear, Side of Face)	☐	☐	Finger or Lip Sucking Habit
☐	☐	Sore or Bleeding Gums	☐	☐	Tooth Sensitivity to Heat, Cold, or Sweets	☐	☐	Fear of Dental Work
☐	☐	Permanent Tooth Extraction	☐	☐	Previous Orthodontic Treatment	☐	☐	Clenching or Grinding
☐	☐	Difficulty Chewing	☐	☐	Head/Neck, Jaw or Tooth Injury	☐	☐	Missing/Extra Permanent Teeth
☐	☐	Clicking or Popping of the Jaw Joints						

I acknowledge that the above information is correct. I will notify Longmont Braces of any changes that occur after this date. I hereby authorize Longmont Braces and its designees to perform an initial orthodontic evaluation/examination.

Name:_____ Date:_____