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

About Your Child

Today's Date________________________

Patient's Name__________________________________ Preferred Name/Nickname____
Street Address____
City______________________ State___________Zip_________________Home Phone___________________________________
Birth Date____/____/____ Age________ Sex ☐M ☐ F School____________________________________Grade______________

Parents or Guardians

Patient lives with: ☐ Both parents together ☐ Both parents separately ☐ Mother ☐ Father ☐ Other________________________
Father/Guardian___________ Employer____________________ Day Phone_________________ Cell Phone__________________
Mother/Guardian___________ Employer____________________ Day Phone_________________ Cell Phone_________________
Parents Address (If different from patients)_________________________________City____________ State______ Zip____________
Parent's Email__________________________
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 relationship to this patient________________________________

Medical Health Information

Is patient adopted? ☐ Yes ☐ No At what age?__________________
Name of child's 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
☐	☐	Tonsillitis	☐	☐	High or Low Blood Pressure	☐	☐	Drug or Alcohol Dependency
☐	☐	Heart Defect, Heart Murmur, Heart Disease				☐	☐	Tonsils or Adenoids Removed

If female, has she begun menstruating?___________________ Pregnant?___________________
Does your child have any disease, condition, or problem not listed that you think we should know about? Please Explain:
____
Is your child taking any medication at this time? ☐ Yes ☐ No If yes, Please list____

Dental Insurance Information

Primary Insurance Company Name____

Dental Health Information

Is your child experiencing any dental problems? ☐ Yes ☐ No Date of last dental visit____/____/____
How often does your child brush and floss each day? Brush ___ times per day Floss ___ times per day
Child's Dentist________________________________ Address___________________________________Phone_________________
Does your child have or has he/she had any of the following diseases or 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	☐	☐	Extra Permanent Teeth
☐	☐	Missing Permanent Teeth	☐	☐	Clicking or Popping of the Jaw Joints	☐	☐	Chronic Mouth Breather

Personal Information

Does the patient have any siblings? ☐ Yes ☐ No If yes, what are their ages?____
Please list any special interests of the patient (sports, hobbies, etc.)____
Patient's attitude about orthodontic treatment: ☐ Very Motivated ☐ Will Cooperate (if needed) ☐ Not Motivated

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______________________
(Parent or Guardian)