STOWERS
ORTHODONTICS

Loveland, CO • 2520 Abarr Drive • 970.667-9193

WELCOME TO OUR OFFICE! Please take a few minutes to complete this form. If you have any questions we would be happy to help. We look forward to working with you in maintaining your dental health.

Whom may we thank for referring you to our office?_____

Patient Name: _____
Address:_____
Phone: Home _____ Work _____ Cell_____
Driver's license#_____State____Email_____
Birthday: ____/____/_____ Age _____ Sex: Male _____ Female _____
Marital Status: Married____ Single____ Widowed ____ Separated ____ Divorced ____

Under Age 18 only

Fathers Name:_____ Mothers Name:_____
Driver's license#:_____State____Email_____
Address:_____
Phone: Home_____ Work_____ Cell_____
Emergency contact:_____Realationship:_____

Guardian Name:_____
Address:_____
Phone: Home _____ Work _____ Cell _____
Email:_____

Why are you interested in orthodontic treatment for you child?_____
_____
How often does your child brush?_____ Floss? _____

Does your child have any habits/problems affecting the mouth or teeth?_____
_____
Which musical instruments does your child play?_____

Dental Insurance Information

Primary Carrier:

Name of insured: _____ Birthday: ____/____/____
Subscriber # or SS #: _____ Group # :_____
Employer: _____ Occupation: _____
Insurance Co. Name: _____ Ins. Phone #:_____

Secondary Carrier:

Name of insured:_____ Birthday: ____/____/____
Subscriber # or SS #:_____ Group #: _____
Employer: _____ Occupation: _____
Insurance Co. Name:_____ Ins. Phone #:_____

Dental Health Information

General Dentist:_____ Date of last dental care ____/____/____
Has patient ever been evaluated for orthodontic treatment? Y____ N____
Has patient experienced pain or discomfort in jaw joint? Y____ N____
Has patient experienced a mouth or chin injury? Y____ N____
Does patient usually breathe through mouth when awake? Y____ N____
When asleep? Y____ N____
Has patient every experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y____ N____
Other information about your dental health or previous treatment: _____
_____

Medical Information

Physician's name _____Date of last visit ____/____/____
Has patient had any serious illnesses or operations? Y____ N____
If yes, please describe_____
Is patient currently under a physicians care? Y____ N____
If yes, please describe_____
Has patient ever had a blood transfusion? Y____ N____
Has patient ever taken Fen-Phen/Redux? (weight loss drug) Y____ N____
List any medications the patient is currently taking:_____
List drug allergies: _____
_____

Check [√] if patient has had any of the following:

[ ] AIDS/HIV Positive
[ ] Alcohol/Drug Abuse
[ ] Anaphylaxis
[ ] Anemia
[ ] Arthritis, Rheumatism
[ ] Artificial heart valve
[ ] Artificial joints
[ ] Asthma
[ ] Atopic (allergy prone)
[ ] Autoimmune Disease
[ ] Back Problems
[ ] Blood disease
[ ] Cancer
[ ] Chemical dependency
[ ] Cholesterol problems
[ ] Chemotherapy
[ ] Circulatory problems
[ ] Cortisone treatments
[ ] Cough persistent
[ ] Cough up blood
[ ] Diabetes
[ ] Epilepsy
[ ] Fainting
[ ] Food Allergies
[ ] Glaucoma
[ ] Headaches
[ ] Heart Murmur
[ ] Heart problems
Describe: _____
[ ] Hemophilia/
Abnormal Bleeding
[ ] Hearing Impairment
[ ] Hereditary Problems
[ ] Herpes
[ ] Hepatitis
[ ] High blood pressure
[ ] Jaw Pain
[ ] Kidney disease
or malfunction
[ ] Liver disease
[ ] Material allergies (latex,
wool, metal, chemicals)
[ ] Mitral valve prolapse
[ ] Nervous problem
[ ] Other_____
[ ] Pacemaker/Heart Surgery
[ ] Psychiatric care
[ ] Rapid Weight Gain or Loss
[ ] Radiation treatment
[ ] Respiratory disease
[ ] Rheumatic/Scarlet Fever
[ ] Seizure
[ ] Shingles
[ ] Shortness of Breath
[ ] Sinus problems
[ ] Skin Rash
[ ] Spina bifida
[ ] Stroke
[ ] Surgical implant
[ ] Swelling of
feet or ankles
[ ] Thyroid disease
or malfunction
[ ] Tobacco habit
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Trauma to the Face/Mouth
[ ] Ulcer/Colitis
[ ] Venereal disease

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the orthodontist.

I authorize my insurance company to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance

Signature: _____ Date:_____

***Payment is due in full at time of treatment, unless prior arrangements have been approved**