

Broadbent Orthodontics
Richard S. Broadbent, D.M.D., M.S.
Specialist in Adult and Child Orthodontics

Date _____

Patient Information

Name _____ Preferred Name: _____

Date of Birth _____ Age _____ Gender Male Female

Address _____ City: _____ State _____ Zip _____

Phone (____) _____ Cell Phone (____) _____ Text reminders: Yes No

If Student, Name of School _____ Grade _____

Parent's Name _____

Who may we thank for recommending our office to you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Relationship to Patient: Parent Other

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone(____) _____ Cell Phone (____) _____ Email _____

Social Security Number _____ Birthdate _____

Employer _____ Occupation _____ Work Phone (____) _____

IF MARRIED:

Spouse Name _____ Relationship to Patient _____

Cell Phone (____) _____ Email _____

Social Security Number _____ Birthdate _____

Employer _____ Work number (____) _____

Patient lives with _____

Additional Responsible Party: _____

All responsible parties will be required to sign financial documents

Dental Insurance Information

Employee Name _____ DOB _____ Relationship to Patient _____

SSN _____ Name of Employer _____ Work Phone (____) _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID# _____

Ins Co Address _____ Ins Co. Phone _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Employee Name _____ DOB _____ Relationship to Patient _____

SSN _____ Name of Employer _____ Work Phone (____) _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID# _____

Ins Co Address _____ Ins Co. Phone _____

Dentist

Patient's Dentist _____ Address _____

Last visit _____ Reason _____ Next Appt _____

Other Dental Specialists _____

General Information

What do you think is the patient's orthodontic problem? _____
What do you think orthodontics will accomplish? _____
How does your child feel about orthodontic treatment? _____
Who suggested that your child might need orthodontic treatment? _____
Has the patient had any injuries to the face, mouth or neck? _____
Has the patient had a history of finger or thumb sucking? _____ Until what age? _____
Is the patient a mouth breather? _____ Have you been informed of any missing or extra permanent teeth? _____
Describe any previous orthodontic treatment or consultations _____
Have any family members had orthodontic treatment? _____ Were they treated at this office? _____

Health Information

Your answers are for office records only, and are confidential. A thorough medical history is essential to complete orthodontic evaluation.

Physician: _____ Phone _____

Is the patient under Physician's care? _____ If yes, explain _____

For the following questions, please mark yes, no or don't know/understand (dk/u). Check all that apply

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Birth defects or hereditary problems? | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Bone fractures or <input type="checkbox"/> major injuries? Explain _____ | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Cancer <input type="checkbox"/> tumor <input type="checkbox"/> radiation treatment or <input type="checkbox"/> chemotherapy? Explain _____ | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Tonsil or <input type="checkbox"/> adenoid conditions? | Has your child had allergies or reactions to any of the following? | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Diabetes or <input type="checkbox"/> low sugar? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Local anesthetics (Novocain, lidocaine...) |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Kidney problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Latex (gloves, balloons) |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Immune system problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Aspirin |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Sexually transmitted diseases? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Ibuprofen (Motrin, Advil) |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | AIDS or HIV positive? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Penicillin |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Hepatitis <input type="checkbox"/> jaundice or <input type="checkbox"/> liver problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Other antibiotics |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Seizures <input type="checkbox"/> fainting spells <input type="checkbox"/> neurologic problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Metals (jewelry, snaps) |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Mental health problems or depression? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Acrylics |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Eating disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | other _____ |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Headaches or migraines? | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> High or <input type="checkbox"/> low blood pressure | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Excessive bleeding or <input type="checkbox"/> bruising tendency? | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Heart defects <input type="checkbox"/> heart murmur <input type="checkbox"/> rheumatic heart disease <input type="checkbox"/> other heart problems? Explain _____ | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | <input type="checkbox"/> Asthma <input type="checkbox"/> sinus problems or <input type="checkbox"/> hay fever? | | |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u | Does the patient smoke? | | |

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company. I authorize and request my insurance company to pay directly to Dr. Richard S. Broadbent, the amount on any claims for service rendered to my dependent. I further agree that should the amount be insufficient to cover the orthodontic expense, I shall be responsible for the difference and if the nature of the disability is such that it is not covered by the policy, I will be responsible to Dr. Richard S. Broadbent for payment of the entire bill.

Primary InsuredX _____ Date _____

Secondary InsuredX _____ Date _____

I hereby authorized Dr. Richard S. Broadbent to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the orthodontic care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I agree to be fully responsible for total payment of procedures performed in this office including any amounts which are not covered by any dental insurance company that I may have. I certify that the above information is complete and accurate.

Responsible Party X _____ Date _____