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 (______)___________________ Work Phone (_____) ___________________ Cell Phone (______)______________________

Text reminders: Yes ☐ No ☐ Email Address____

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

Person to contact in case of emergency____ Phone__________________________

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ 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 (___)____

Dental Insurance Information

Employee Name____________________________________DOB__________________Relationship to Patient __________________

SSN__________________________ Name of Employer:______________________________ Work Phone (____)________________

Address of Employer____City__________________State:________Zip ___________

Name of Insurance Company___________________________________ Group #_________________ ID#______________________

Ins Co Address____ Ins Co. Phone:_____________________________

DO YOU HAVE ANY ADDIONAL 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

Dentist____ Address____

Last visit ___________________________________ Reason________________________________ Next Appt____________________

Other Dental Specialists____

General Information

What do you think is your orthodontic problem?________________________________

What do you think orthodontics will accomplish?________________________________

How do you feel about orthodontic treatment?________________________________

Who suggested that you might need orthodontic treatment?________________________________

Have you had any injuries to the face, mouth or neck?________________________________

Have you had a history of finger or thumb sucking?________________ Until what age?________________________

Are you 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________________________________

Are you under Physician's care?________ If yes, explain________________________________

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

☐yes ☐no ☐dk/u Birth defects or hereditary problems?

☐yes ☐no ☐dk/u Bone fractures, or major injuries? explain________________________________

☐yes ☐no ☐dk/u ☐Cancer ☐tumor ☐radiation treatment or chemotherapy?

☐yes ☐no ☐dk/u ☐Tonsil or ☐adenoid conditions?

☐yes ☐no ☐dk/u ☐Diabetes ☐low sugar?

☐yes ☐no ☐dk/u Kidney problems?

☐yes ☐no ☐dk/u Immune system problems?

☐yes ☐no ☐dk/u Sexually transmitted diseases?

☐yes ☐no ☐dk/u AIDS or HIV positive?

☐yes ☐no ☐dk/u ☐Hepatitis ☐ jaundice or ☐liver problems?

☐yes ☐no ☐dk/u ☐Seizures ☐fainting spells ☐neurologic problems?

☐yes ☐no ☐dk/u Mental health problems or depression?

☐yes ☐no ☐dk/u Eating disorders?

☐yes ☐no ☐dk/u Headaches or migraines?

☐yes ☐no ☐dk/u ☐High or ☐low blood pressure

☐yes ☐no ☐dk/u ☐Excessive bleeding or ☐bruising tendency?

☐yes ☐no ☐dk/u ☐Heart defects ☐heart murmur ☐rheumatic heart disease ☐other heart problems?________________________

☐yes ☐no ☐dk/u ☐Asthma ☐sinus problems or ☐hay fever?

☐yes ☐no ☐dk/u Does patient smoke?

Have you had allergies or reactions to any of the following?

☐yes ☐no ☐dk/u Local anesthetics (Novocain, lidocaine…)

☐yes ☐no ☐dk/u Latex (gloves, balloons)

☐yes ☐no ☐dk/u Aspirin

☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)

☐yes ☐no ☐dk/u Penicillin

☐yes ☐no ☐dk/u Other antibiotics

☐yes ☐no ☐dk/u Metals (jewelry, snaps)

☐yes ☐no ☐dk/u Acrylics

☐yes ☐no ☐dk/u other____________________________

Release and Waiver

I authorize release of any information regarding my 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 me. 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 Insured X________________________________ Date________________________

Secondary Inured X________________________________ Date________________________

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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 myself 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________________________