**Laura D. Milnor D.D.S., M.S.**
1103 S. Shields St.
Fort Collins, CO 80521
970.484.3214

**Patient Information**

Patient's Name ________________________________________ Nickname _________________

Date of Birth ______________________Age ___________Gender ____________

School _______________________________________ Grade ______________

Home Address _____________________________________________________________________

City, State, Zip Code __________________________________________Phone#____________________

**Responsible Party**

Name _________________________________________ Relationship to Patient ____________________

Employers Name ______________________________________ SSN ______________________________

Billing Address (if different from patients) ___________________________________________________

City, State, Zip Code ______________________________________________________________________

Phone #: Home ___________________Work _____________________Cell ______________________

**Dental Insurance** (please bring your insurance card to the first appointment)

Provider's Name_____________________________ Policy Holder _______________________________

Policy Number _________________________________ Group Number __________________________

Policy Holders Employer _______________________________

Patient Relationship to Insured (please circle one): Self Child Husband Wife Other __________

**Other**

How did you hear about our office? ________________________________________________________

Have you had previous orthodontic treatment? Yes No If yes when?______________________________

Has anyone in your family had orthodontic care with us?_______________________________________

What is the reason for your consultation?___________________________________________________

Is there anything you would change about your smile or appearance? _____________________________

_____________________________________________________________________________________

Do you currently, or have you ever had pain/discomfort with your jaw joint (TMJ)? Yes_____ No______

If yes please describe.________________________________________________________________

Have you been in any accidents or had any trauma that affected your teeth or jaws? Yes_____ No______

If yes please describe. ________________________________________________________________

**Personal**

What do you enjoy doing (sports, hobbies)?______________________________________________

**Medical History** (Please circle either Yes or No)

Are you in good health? Yes No

Do you take any medications? Yes No

If yes please list?____________________________________________________________

Do you have any of the following:

Yes No Heart Problems (Murmers, Congenital Defects etc.)?_________________________________

Yes No Allergies to any medications?

Yes No Allergies to latex?

Yes No Seasonal Allergies?

Yes No Asthma?

Yes No Diabetes?

Yes No Hepatitis?

Yes No HIV +/ AIDS

Yes No Kidney / Liver Problems?

Yes No Rheumatic Fever?

Yes No Seizures/Epilepsy?

Yes No Cancer?______________________________________________________

Yes No Chronic headaches?

Yes No Sinus problems?

Yes No Growths or swellings in you mouth?

**Dental History** (Please circle either Yes or No)

Yes No Have you had a dental check-up within the last 6 months?

Yes No Do you clench or grind your teeth?

Yes No Do you suffer from frequent canker sores?

Yes No Do you have any oral habits? (thumb-sucking, nail-biting, pen-biting etc..)

Yes No Do you have a history of gum disease or periodontitis?

I hereby certify to the best of my knowledge that the above Medical/Dental history is accurate and current. If there are any changes it is my responsibility to inform Dr. Milnor as soon as possible. **(A Parent or Legal Guardian must sign below if the patient is under 18 years of age)**

______________________________ ____________________

Signature Date

**Acknowledgement of Receipt of Notice of Privacy Practices**

I ______________________________, have received a copy of Dr. Milor's Privacy Policy.

______________________________ ____________________

Signature Date