



**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. \_\_\_\_\_

**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 (Murmurs, 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    History of, or currently taking bisphosphonates (Fosamax etc.)?

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

I \_\_\_\_\_, have received a copy of Dr. Milnor's Privacy Policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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