# NORTHERN COLORADO ORTHODONTICS
**Jill K. Mioduski, DDS, MS**

## Patient Information
Title: _____ First Name: ______________________MI: _____ Last Name: __________________ Preferred: _______________ Gender: M or F
Date of Birth: ____________________ Age: _______ SSN#________________________ Driver's License Number: ________________
Mailing Address: ____________________________________________ City: ___________________ State: ____ Zip: ________
Home Phone: (_______)________________ Work Phone: (______) ________________ Cell Phone (_______)____________________
Best contact number: ☐ Home Phone ☐ Work phone ☐ Cell phone
Employer: ____________________________ Occupation: ___________________________ Years of Employment: ___________
Whom may we thank for referring you? ___________________________________________________________________
Related patients that are or have been in our care: ____________________________________________________________

## FINANCIAL INFORMATION

### Financially Responsible Party Information
Title: _____ First Name: ______________________MI: _____ Last Name: __________________ Relationship to Patient: _____________
Date of Birth: _________________ SSN#________________________ Driver's License Number: ________________
Address: (if different than patient's)_____________________________________ City: ___________________ State: ____ Zip: ________
Home Phone: (_______)________________ Work Phone: (______) ________________ Cell Phone: (_______) ___________________
Best contact number: ☐ Home phone ☐ Work phone ☐ Cell phone Email Address: ________________________________________
Employer: ____________________________ Occupation: ___________________________ Years of Employment: ___________

## INSURANCE INFORMATION

### Primary Insurance (Dental only)
Name of Insured: ________________________________________ Date of Birth: _____________ SSN#: ________________________
Relationship to Patient: ______________________ Employer: ________________________________________
Insurance Company: _________________________________ Grp #: _________________________ ID#___________________________
Ins Co Address: ______________________________________________________ Ins Co. Phone: _________________________________

### Secondary Insurance (Dental only)
Name of Insured: ________________________________________ Date of Birth: _____________ SSN#: ________________________
Relationship to Patient: ______________________ Employer: ________________________________________
Insurance Company: _________________________________ Grp #: _________________________ ID#: ________________________
Ins Co Address: ______________________________________________________ Ins Co. Phone: ________________________________

## EMERGENCY INFORMATION
Nearest friend/relative not living with you: _____________________________________________________ Phone: ________________
First Last Relationship
Address: ________________________________________________________________________________ Phone: ________________
Street City State Zip

## MEDICAL HISTORY
Name of Physician: _______________________________ Are you currently under the care of a physician?_____________________________
History of hospitalizations/surgery/serious illness: ___________________________ Require premedication for dental visits: ☐ Y ☐ N
Please list any medication and reason for taking:___________________________________________________________________________
Do you have any allergies to: Latex ? ☐ Y ☐ N Metals/Jewelry? ☐ Y ☐ N
Please list any other allergies including medications: _________________________________________________________________________

***Please circle any past or current conditions that apply and describe as necessary:***

| | | | | |
|---|---|---|---|---|
| Heart problems | Diabetes | Chemotherapy | Eye disease | Bisphosphonate use |
| Heart murmur | Depression/anxiety | Radiation therapy | Bone disease | Cold sores |
| Congenital heart disease | Psychiatric therapy | Thyroid problems | Lung disease | Tonsils/adenoids removed |
| Endocarditis | Seizures/Epilepsy | Blood disorder | Kidney disease | Tobacco use |
| Heart transplant | Fainting | Anemia | Tuberculosis | Drug use |
| Artificial heart valve | ADD/ADHD | Handicap/disability | Asthma | Arthritis/joint problems |
| Artificial joint | Emotional Problems | Hepatitis | Breathing problems | Ulcers |
| Stroke | Cancer | Liver disease | HIV/AIDS | |

Other ____________________________________________
Females:
Are you currently pregnant? ☐ Y ☐ N Date of first menstruation: ___________________

**OVER ➔**

1295 Main Street, #4 Windsor, CO 80550
970-674-0717 970-460-9148 (fax)
info@nocoortho.com

## DENTAL/ORTHODONTIC HISTORY

Dentist Name: _________________________ Phone: ________________ Date of Last Dental Visit: _________________________

Dentist Address: __________________________________________ City: __________________ State: ___ Zip: ________

What is the main reason for your orthodontic visit today? _____________________________________________________________

Have you ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N Explain: ________________________________________

***Any current or past history of:***

| | | |
|---|---|---|
| Thumb/finger sucking | Lip biting | Mouth breathing/snoring |
| Teeth grinding/clenching | Injury to the face, mouth or jaws | Missing or extra permanent teeth |
| Nail biting | Speech therapy | Tongue thrusting |

## RELEASE AND WAIVER

**I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.**

Patient Signature _________________________________________________________ Date _____________________

**I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.**

Patient Signature _________________________________________________________ Date _____________________

**By providing us with your landline or cell phone number(s), you give express authorization to contact you at those numbers. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology.**