NORTHERN COLORADO ORTHODONTICS

Jill K. Mioduski, DDS, MS

Patient Information

First Name: _____ MI: _____ Last Name: _____ Preferred: _____ Gender: M or F
Date of Birth: _____ Age: _____ School (If Student): _____ Grade: _____
Mailing Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____)_____
Best contact number: ☐ Home Phone ☐ Work phone ☐ Cell phone
Parents' relationship status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Other _____
Patient lives with: ☐ Mother ☐ Father ☐ Both ☐ Other _____
Who will be responsible for bringing the patient to their orthodontic appointments? _____
Whom may we thank for referring you? _____
Please list any siblings and their ages: _____
Related Patients that are or have been in our care: _____

PARENT INFORMATION

Mother's Information

Title: _____ First Name: _____ MI: _____ Last Name: _____ Preferred: _____
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: _____
Spouse: _____
Custody: ☐ Sole ☐ Joint ☐ None Any custody restrictions we need to be aware of? ☐ YES ☐ NO

Father's Information

Title: _____ First Name: _____ MI: _____ Last Name: _____ Preferred: _____
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: _____
Spouse: _____
Custody: ☐ Sole ☐ Joint ☐ None Any custody restrictions we need to be aware of? ☐ YES ☐ NO

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: _____

OVER ➔

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

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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: _____

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 child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian 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 child's medical or dental health.

Parent/Guardian 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.

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