20mile
ORTHODONTICS LLP
20 MILES WORTH OF SMILES
www.20mileortho.com
303.841.2262

1 PATIENT INFORMATION

Date: _____
Patient's Name: _____
Last First Middle
Address: _____
Street City State Zip
Home Phone: _____ Birthday: _____ Age: _____
General Dentist: _____
How did you hear of our office: _____

2 RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle Marital Status
Residence: _____
Street City State Zip
Mailing Address: _____
Street City State Zip
How Long at this address: _____ Home Phone: _____ Work Phone: _____
Previous address (if less than 3 years) _____
Street City State Zip
Social Security #: _____ Birthdate: _____ Relationship to Patient: _____
Employer: _____ Occupation: _____ No. Years Employed: _____
Spouse's Name: _____ Relationship to Patient: _____
Last First Middle
Social Security #: _____ Birthdate: _____ Work Phone: _____

3 INSURANCE INFORMATION

Insured's Name: _____ Insured's Soc. Sec. #: _____
Insurance Co.: _____ Group No: _____ Telephone # _____
Insurance Co. Address: _____
Street City State Zip
Insured's Employer: _____
Do you have dual coverage: Yes No If yes
Insured's Name: _____ Insured's Soc. Sec. #: _____
Insurance Co.: _____ Group No: _____ Telephone # _____
Insurance Co. Address: _____
Street City State Zip
Insured's Employer: _____

4 EMERGENCY INFORMATION

Name of nearest relative not living with you: _____
Complete Address: _____
Phone: _____
Signature (Parent's signature if minor): _____ Date: _____
Updates (dates/Initial): _____

(Over)
Please complete information on other side

5 DENTAL HISTORY

What are the main concerns that you would like Orthodontics to accomplish?

_____

_____

_____

Has your child ever been evaluated or had orthodontic treatment before?

❑ Yes ❑ No

Have ther ever been any injuries to the face, mouth, teeth or chin?

❑ Yes ❑ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth?

❑ Yes ❑ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Does your child brush his her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: ( ) _____ Date of last visit: _____

Is your child currently under the care of a physician? ❑ Yes ❑ No

Please describe your child's current physical health:

❑ Good ❑ Fair ❑ Poor

Does your child have any speech problems?_____

_____

Please list all drugs that your child is currently taking?_____

_____

Please list all drugs that your child is allergic to:_____

_____

6 MEDICAL HISTORY

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Abnormal Bleeding
Y	N	Allergies to any Drugs	Y	N	Handicaps/Disabilities
Y	N	Allergic to Latex/Metal	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney/Liver Problems
Y	N	Congenital Heart	Y	N	Rheumatic/Scarlet Fever
Y	N	Convulsions/Epilepsy	Y	N	Tuberculosis

Please Discuss any medical problems that your child has had

_____

_____

_____

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_____

_____

7 HABITS

Does / did your child have any of the following habits?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Thumb / Finger Sucking
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting			

Comments: _____

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