Dr. Lisa M. Austin, DMD, MSD
Orthodontics for Children and Adults

10050 W 41st. Ave. Suite 102 **Wheat Ridge, CO** 80033
(303)940-5659

About you

Name: ______________________________
First Last
I prefer to be called: ______________________
Birthdate: ____________ ☐Male ☐Female
SS#________________
Home Address: ________________________
City, State, Zip: ________________________
☐Single ☐Married ☐Divorced
☐Widowed ☐Separated
Cell phone # __________________________
Home # _____________ Work # ___________
Email ______________________________
Please use ☐Home ☐cell ☐work to contact me
Occupation: ___________________________
How Long: ___________
Employer: ____________________________
Employer address: ______________________

Whom may we thank for referring you?

____

In the event of an emergency, please contact:

____

Dental Insurance

Primary Dental Insurance

Insurance Company: ______________________
Insurance Co Address: ____________________
Insurance Co Phone # _____________________
Group Number: ___________________________
Relationship to patient: ___________________
Policy Owners Birthdate: __________________
Policy Owners SS # _______________________
Policy Owners Employer: __________________

Secondary Dental Insurance

Insurance Company: ______________________
Insurance Co Address: ____________________
Insurance Co Phone # _____________________
Group Number: ___________________________
Relationship to patient: ___________________
Policy Owners Birthdate: __________________
Policy Owners SS # _______________________
Policy Owners Employer: __________________

Spouse/Partner Information

His/her Name: __________________________
Employer: _____________________________
Cell # ____________________
Work# ____________________
Birthdate: __________________
SS# ______________________

General Dentist: __________________________
Phone number and location: _______________

____

Date of last visit: _________________________

What are your main concerns that you would like orthodontics to accomplish?

____

Health History

Your current medical history is
☐Good ☐ Fair ☐Poor

Are you currently under the care of a physician?
☐Yes ☐no

Physician's name: ______________________________

Phone # ______________________________

Do you take any prescription/over-the-counter drugs?
☐Yes ☐no

If yes, please list: ______________________________
____

Please check any of the following diseases or medical problems that you have:

☐Abnormal bleeding	☐Tuberculosis
☐Artificial bones/joints/valves	☐Hemophilia
☐Arthritis	☐Hepatitis
☐Asthma	☐High Blood Pressure
☐Blood transfusion	☐Low Blood Pressure
☐Cancer	☐HIV+/AIDS
☐Chemotherapy	☐Hospitalization
☐Congenital Heart Defects	☐Kidney Problems
☐Diabetes	☐Mitral Valve Prolapse
☐Difficulty Breathing	☐Psychiatric Problems
☐Drug or Alcohol abuse	☐Rheumatic Problems
☐Emphysema	☐Shingles
☐Epilepsy	☐Sinus Problems
☐Fainting	☐Sinus Problems
☐Fever Blisters	☐Seizures
☐Herpes	☐Heart Attack
☐Glaucoma	☐Ulcers/Colitis
☐Heart Murmur	☐Venereal Disease
☐Anemia/Radiation treatment	
☐Heart Surgery/Pacemaker	

Are you pregnant? ☐Yes ☐No

Have you ever had a serious/difficult problem with any previous dental work? Explain:

Your current dental health is ☐good ☐fair ☐poor

Do you like your smile? ☐Yes ☐no

Do your gums ever bleed? ☐Yes ☐no

Do you have any missing teeth ☐Yes ☐no

Do you have any extra teeth ☐Yes ☐no

Do you generally breathe through your mouth?
☐Yes ☐no

If yes, ☐while awake? ☐while asleep

Have you ever had an injury to your:
☐mouth ☐teeth ☐chin

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?☐Yes☐ no

Have you ever had any of the following?

☐Toothache	☐Difficulty Swallowing
☐Snoring	☐Difficulty Chewing
☐Teeth Grinding	
☐Pain or clicking when opening mouth	

Please list any serious medical condition(s) that you have ever had: ______________________________

Are you allergic to any of the following? (please check those that apply)

☐Aspirin	☐Erythromycin
☐Codeine	☐Latex
☐Tetracycline	☐Penicillin
☐Dental Anesthetics	☐Metal
☐Plastics	

Please list any other drugs/materials that you are allergic to: ______________________________

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Legal Name Signature: ______________________________