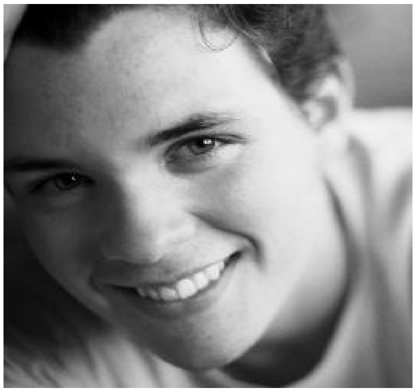

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.
Thank you!

Today's date: ____________________

ABOUT YOUR TEEN

Name: ____ o Female o Male

Nickname: ____

Address: ____

City:____________________________State: ________Zip: ________________

Home phone: ____________________ Cell phone: ______________________

School: _________________________________ Grade: __________________

Birth date: _____/_____/_____ Social security number: ________________

Email for appointment reminders: __________________________________

Fathers Name: ____

Birth Date:_____/_____/_____ Social security number: ________________

Work phone: ____________________ Cell phone: ______________________

Employer: ____

Insurance Co.: __________________________ Group: __________________

ID #:__________________________ Ins. Phone: ______________________

Mothers Name: ____

Birth Date:_____/_____/_____ Social security number: ________________

Work phone: ____________________ Cell phone: ______________________

Employer: ____

Insurance Co.: __________________________ Group: __________________

ID #:__________________________ Ins. Phone: ______________________

Who is responsible for child's account: _______________________________

EMERGENCY INFORMATION

Person to contact: ______________________Relationship: _______________

Phone: ____

4185 E. Wildcat Reserve Pkwy. Ste 300, Highlands Ranch, CO 80126 Phone 303-683-2300 Fax 303-346-8014

DENTAL HISTORY

How do you feel about your smile? ____

What was your approximate age at your first dental experience? __________

Has your dental care been regular? o Yes o No

Are you currently in braces? o Yes o No How much longer? _________________

Have you ever had: o orthodontic treatment? o oral surgery? o root canal treatment?

o clicking or popping of the jaw joint (TMJ)? o sensitivity to heat, cold or pressure?

How do your brush your teeth? o vigorously o moderately o lightly o what's brushing

How often do you brush your teeth?_____________ How often do you floss your teeth?_____________

Do you smoke or chew tobacco? o Yes o No How often? __________________________________

How many sodas to you drink a day? _______ What kind? ___________________________________

How many times a day do you snack? _____________ What do you snack on? ___________________

MEDICAL HISTORY

When was your teens last medical exam? Date ________________________________Year _________

Has your teen required hospitalization or had a serious illness? o Yes o No

If yes, please explain: ____

Are your teens immunizations up-to-date? o Yes o No

Is your teen sensitive/allergic to anything? o Yes o No

If yes, please explain: ____

Is your teen presently taking any medications? o Yes o No

If yes, please explain: ____

Please check any of the following that apply to your teen:

o Rheumatic fever	o Asthma	o Diabetes	o Penicillin/Amoxicillin Allergy
o Heart murmur	o Hay fever	o Breathing disorders	o Mitral valve prolapse
o Epilepsy	o Anemia	o Pregnancy	o HIV/AIDS
o Attention disorder	o Latex Allergy	o Hepatitis	o Sulfa Allergy
o Cold sores/fever blisters	o Cancer	o Drug Addiction	o Venereal Disease

Is there any additional health information or concerns you would like us to know about?

____

Teen Signature ____ ***Date*** ________________

Guardian Signature ____ ***Date*** ________________

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