

WELCOME TO OUR OFFICE -

David E. Lindeman D.D.S., M.S., P.C.
6881 S. Holly Circle, Suite 109
Centennial, CO 80112
(303) 740-7806

So that we might become better acquainted, please complete this form.

ADULT PATIENT INFORMATION

Patient's Name _____ Prefer to be called _____ Sex _____

Mailing Address _____ City _____ Zip _____

e-mail Address _____ Home Phone _____

Age _____ Birth date _____

Patient's Dentist _____ Phone Number _____

Referred by _____ Do you know a patient currently in our practice? Whom _____

Who noticed the orthodontic problem? Patient Dentist Other _____

Describe the orthodontic problem in your own words _____

What concerns you most about the thought of orthodontic treatment?

appearance in appliances cost length of time discomfort results other _____

Occupation _____ Employer _____

Address _____ Work Phone _____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name _____ Employer _____ Wk Phone _____

Person responsible for account _____

If other than self or spouse:

Name _____ Occupation _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and ***the patient or person responsible for the account is responsible for payment of all fees incurred.*** For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, we ask that you provide us with a claim form from your insurance carrier on your first visit or as soon as possible. Otherwise we will assume you are submitting all claims to your insurance carrier and the fees will be due in full from you at time of service or billing.

Primary Insurance

Name of insured (Employee) _____ ID# _____ DOB _____

Insurance Co. _____ Group # _____ Ins. Phone # _____

Insurance Claims Address: _____

Employer _____

Secondary Insurance

Name of insured (Employee) _____ ID# _____ DOB _____

Insurance Co. _____ Group # _____ Ins. Phone # _____

Employer _____ Ins. Claims Address: _____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name _____ Phone _____

- Have you experienced any health problems? [] No [] Yes Explain: _____
- Any major change in your health recently? [] No [] Yes Explain: _____
- Are you currently under physician's care? [] No [] Yes Explain: _____
- Are you currently taking medications? [] No [] Yes List: _____
- Are you allergic to any medications? [] No [] Yes List: _____
- Are you allergic to latex or metals? [] No [] Yes List: _____
- Have you received a blood transfusion? [] No [] Yes Reason: _____
- Have your tonsils or adenoids been removed? [] No [] Yes When: _____
- Have you been in a risk group for AIDS? [] No [] Yes Explain: _____

- | | | |
|---------------------------------------|-------------------------------|--|
| Heart Murmur [] No [] Yes | Hepatitis [] No [] Yes | Emotional Problems [] No [] Yes |
| Heart Surgery [] No [] Yes | Diabetes [] No [] Yes | Frequent Headaches [] No [] Yes |
| Rheumatic Fever [] No [] Yes | Kidney Disease [] No [] Yes | Nervous/Anxious [] No [] Yes |
| Endocrine Disorders [] No [] Yes | Liver Disease [] No [] Yes | Cancer [] No [] Yes |
| Prolonged Bleeding [] No [] Yes | Tuberculosis [] No [] Yes | Bone Disorders [] No [] Yes |
| Anemia [] No [] Yes | Bronchitis [] No [] Yes | Growth Disorders [] No [] Yes |
| Blood Disease [] No [] Yes | Asthma [] No [] Yes | AIDS [] No [] Yes |
| Developmental Disorder [] No [] Yes | Epilepsy [] No [] Yes | Herpes(fever blisters) [] No [] Yes |
| Hives/Rash [] No [] Yes | Fainting [] No [] Yes | Tonsillitis [] No [] Yes |

Is there any other condition or problem that you think we should know about? _____
Comments: _____

DENTAL HISTORY

Dentist's Name: _____
Address _____ City: _____ State _____ Zip _____ Phone _____

- Frequency of dental checkups: Twice a year [] Once a year [] Only if a problem exist [] Never [] Date of last visit _____
- Is there any unfinished care to be completed with your dentist? [] No [] Yes Explain: _____
 - Are you frightened about dental treatment? [] No [] Yes Explain: _____
 - Have you had an unpleasant experience in a dental office? [] No [] Yes Explain: _____
 - Have you had any face or dental injuries? [] No [] Yes Explain: _____
 - Do you play any musical instruments? [] No [] Yes What instrument? _____
 - Have you consulted an orthodontist previously? [] No [] Yes Whom? _____
 - Have teeth (either primary or permanent) been removed? [] No [] Yes
 - Have you had any previous orthodontic treatment? [] No [] Yes With whom? _____
 - Are you satisfied with prior treatment? [] No [] Yes Explain: _____
 - Have you noticed any changes in your bite or dental alignment recently? [] No [] Yes Explain: _____

What are the chief concerns you have related to the position of your teeth or bite:
[] Aesthetic [] Cleaning [] Comfort [] Ability to chew [] Stability
Please elaborate: _____

What concern has your dentist(s) expressed concerning your bite or dental alignment:
[] Wear or fractures of teeth [] Difficulty with cleaning related to alignment of teeth
[] Bone or gum tissue loss [] Jaw joint or muscle tightness or discomfort
[] Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)
[] Other _____

Please check if there is a history of:
[] Clenching teeth [] Muscular soreness around head & neck [] Jaw joint soreness [] Jaw joint popping
[] Grinding teeth [] Headaches (more than normal) [] Jaw joint clicking [] Ringing in the ears
[] Speech problems (if so, which sounds _____) [] Mouth breathing:
Awake _____ Asleep _____

Is there any other information that may be helpful? _____
I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes to this record, I will inform this practice.
