Broadbent Orthodontics
Richard S. Broadbent, D.M.D., M.S.
Specialist in Adult and Child Orthodontics

Date_____

Patient Information

Name:_____ Preferred Name: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
Email Address_____Date of Birth:_____

Age_____ Gender ☐ Male ☐ Female

If Student, Name of School_____ Grade_____
Parent's Name:_____
Who may we thank for recommending our office to you?_____
Person to contact in case of emergency_____ Phone_____

Responsible Party

Relationship to Patient: ☐ Parent ☐ Other
Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone: (____)_____ Cell Phone: (___)_____ Email:_____
Social Security Number:_____ Birthdate:_____
Employer_____ Occupation_____ Work Phone (____)_____
IF MARRIED:

Spouse Name_____ Relationship to Patient_____
Cell Phone: (___)_____ Email:_____
Social Security Number_____ Birthdate_____
Employer:_____ Work number (___)_____
Patient lives with:_____

Dental Insurance Information

Employee Name_____DOB_____Relationship to Patient _____
SSN_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____
DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Employee Name_____DOB_____Relationship to Patient _____
SSN_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Dentist

Patient's Dentist_____ Address_____
Last visit _____ Reason_____ Next Appt_____
Other Dental Specialists_____

General Information

What do you think is the patient's orthodontic problem?_____
What do you think orthodontics will accomplish?_____
How does your child feel about orthodontic treatment?_____
Who suggested that your child might need orthodontic treatment?_____
Has the patient had any injuries to the face, mouth or neck?_____
Has the patient had a history of finger or thumb sucking?_____ Until what age?_____
Is the patient a mouth breather?_____ Have you been informed of any missing or extra permanent teeth?_____
Describe any previous orthodontic treatment or consultations_____
Have any family members had orthodontic treatment?_____ Were they treated at this office?_____

Health Information

Your answers are for office records only, and are confidential. A thorough medical history is essential to complete orthodontic evaluation.

Physician:_____ Phone_____
Is the patient under Physician's care?_____ If yes, explain_____
For the following questions, please mark yes, no or don't know/understand (dk/u)

☐yes ☐no ☐dk/u	Birth defects or hereditary problems?		
☐yes ☐no ☐dk/u	Bone fractures, or major injuries?		
☐yes ☐no ☐dk/u	Cancer, tumor, radiation treatment or chemotherapy?		
☐yes ☐no ☐dk/u	Tonsil or adenoid conditions?	**Has your child had allergies or reactions to any of the following?**	
☐yes ☐no ☐dk/u	Diabetes or low sugar?	☐yes ☐no ☐dk/u	Local anesthetics (Novocain, lidocaine…)
☐yes ☐no ☐dk/u	Kidney problems?	☐yes ☐no ☐dk/u	Latex (gloves, balloons)
☐yes ☐no ☐dk/u	Immune system problems?	☐yes ☐no ☐dk/u	Aspirin
☐yes ☐no ☐dk/u	Sexually transmitted diseases?	☐yes ☐no ☐dk/u	Ibuprofen (Motrin, Advil)
☐yes ☐no ☐dk/u	AIDS or HIV positive?	☐yes ☐no ☐dk/u	Penicillin
☐yes ☐no ☐dk/u	Hepatitis, jaundice or liver problems?	☐yes ☐no ☐dk/u	Other antibiotics
☐yes ☐no ☐dk/u	Seizures, fainting spells, neurologic problems?	☐yes ☐no ☐dk/u	Metals (jewelry, snaps)
☐yes ☐no ☐dk/u	Mental health problems or depression?	☐yes ☐no ☐dk/u	Acrylics
☐yes ☐no ☐dk/u	Eating disorders?	☐yes ☐no ☐dk/u	other_____
☐yes ☐no ☐dk/u	Headaches or migraines?		
☐yes ☐no ☐dk/u	High or low blood pressure		
☐yes ☐no ☐dk/u	Excessive bleeding or bruising tendency?		
☐yes ☐no ☐dk/u	Heart defects, heart murmur, rheumatic heart disease, other heart problems?		
☐yes ☐no ☐dk/u	Asthma, sinus problems or hay fever?		
☐yes ☐no ☐dk/u	Does the patient smoke?		

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company. I authorize and request my insurance company to pay directly to Dr. Richard S. Broadbent, the amount on any claims for service rendered to my dependent. I further agree that should the amount be insufficient to cover the orthodontic expense, I shall be responsible for the difference and if the nature of the disability is such that it is not covered by the policy, I will be responsible to Dr. Richard S. Broadbent for payment of the entire bill.

Primary InsuredX_____ Date_____

Secondary InuredX_____ Date_____

I hereby authorized Dr. Richard S. Broadbent to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the orthodontic care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I agree to be fully responsible for total payment of procedures performed in this office including any amounts which are not covered by any dental insurance company that I may have. I certify that the above information is complete and accurate.
Responsible Party X_____ Date_____