DR. COLIN GIBSON DDS, MS
1333 W. 120th Ave. Suite 303
Westminster, CO 80234
303-452-2277
www.1stimpressionsortho.com

PATIENT INFORMATION

Today's Date ________________________ Patients Nickname/what patient goes by: ______________________

Patient's given name ____

Last First Middle Suffix/Title

Address ____

Street City Zip

Birthdate ___________________ Male/Female Age today ________ Soc. Security# ________________

Home phone # ____________________________________ Work phone # ______________________________

****E-mail** ____ ****Mobile phone #** ________________________

If patient is a minor, give parent's or guardian's names ____

Whom may we thank for referring you to our office? ____

Name of General Dentist or Pediatric Dentist ____

Hobbies/Interests __________________________ Names of other siblings? ___________________________

RESPONSIBLE PARTY INFORMATION

Name ____

Last First Middle Suffix/Title

Home Address____

Work Address____

Street City Zip

Home phone #_________________________________ Work phone #_________________________________

****E-mail** _______________________________________ ****Mobile phone #** ____________________________

Social Security # __________________ Date of Birth ______________ Relationship to patient ______________

Employer _____________________________________ Occupation ____________________________________

Employer _____________________________________ Occupation ____________________________________

DENTAL INSURANCE INFORMATION

Policy holder's Name ____________________ DOB: ______________ Insured's Social Security # ____________

Name of Employer____

Does your job offer a "Flexible spending" account? Yes_____ No_____ Don't know_____ What month does it renew?

Insurance Company _________________________ Group No. ____

Insurance Co. Address ____ Phone No. ___________________

Do you have dual coverage? Yes _______ No _______ If yes complete the following below:

Policy holder's Name ____________________________________ Policy holder's Social Security # ____________

Insurance Company _________________________ Group No. __________________ Local No. ________________

Insurance Co. Address ____ Phone No. _________________

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MEDICAL HISTORY OF NEW PATIENT

Patient's Name ____
Physician______________________________ Date of Last Visit______________________
Address______________________________ Phone ______________________________
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ______________________________
Yes No Are you allergic to any medication/latex/or nickel? ______________________
Yes No Do you have a history of major illness? ______________________________
Yes No Have you had any major operations? ______________________________
Yes No Have you ever been involved in a serious accident? ______________________
Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemo
Asthma or Hayfever	GI problems	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? ________________

DENTAL HISTORY OF NEW PATIENT

Dentist ______________________________ Date of last visit ______________________
What concerns you most about your teeth? ______________________________

Yes No Are you presently in any dental pain? ______________________________
Yes No Have you ever experienced any unfavorable reaction to dentistry? ________________
Yes No Have you ever lost or chipped any permanent teeth? ______________________
Yes No Is any part of your mouth sensitive to temperature of pressure? ________________
Yes No Do your gums bleed when you brush? ______________________________
Yes No Has there been any injuries to your face, mouth, or teeth? ______________________
Yes No Do you have any kind of thumb or tongue habit? ______________________
Yes No Are you a mouth breather? ______________________________
Yes No Have you ever seen an orthodontist? If yes, who and when? ______________________
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? ____________
Yes No Has anyone in your family received orthodontic treatment? ______________________
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ________________
Yes No Are you aware of your jaw clicking or popping? ______________________
Yes No Are you aware of clenching your teeth during the day? ______________________
Yes No Have you ever been told that you grind your teeth? ______________________
Yes No Do you have tension headaches? ______________________________
Yes No Are you aware that some appointments will be during school or work hours? ________________
Female patients only:
Yes No Are you pregnant? ______________________________
Yes No Has menstruation started? ______________________________

BENEFITS

Benefits of Orthodontics: Esthetics, Beauty, Health, Function, Confidence, and Success. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the function of the teeth, in the dental and medical health of the patient, and in the overall self-esteem and future success of the patient.

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Gibson to perform a complete orthodontic evaluation.

Signature: ______________________________ Date: ______________
Patient or legal guardian of patient