BELLON
ORTHODONTICS

Orthodontics for Children and Adults

Date: _____

Mr. __ Mrs. __ Ms. __ Miss __ Dr. __ Rev. __ Other _____

Name: _____ S.S.N _____
(Last) (First) (M)

You prefer to be called: _____ Male: _____ Female: _____

Date of Birth: _____ Age: _____ yrs. _____mos. Phone: _____
Mo. Day Year

Address: _____, _____, _____, _____
Street City State Zip

Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse's name: _____ S.S.N.: _____ D.O.B. _____

Home Address: _____ Home Phone: _____

Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Dentist: Dr._____

How were you referred to our office?_____

Insurance Information (Please list all dental coverage)

Name of Insured: (1) _____ ID# (1) _____

(2) _____ ID# (2) _____

Name of Insurance Co.: (1) _____ Ins. Phone # (1) _____

(2) _____ Ins. Phone # (2) _____

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Denver, CO 80224
303.692.9610

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Littleton, CO 80128
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Your careful complete answers to the following questions will be very helpful in the evaluation of your orthodontic problem.

Physician: _____ Address: _____
Date of last physical examination: _____ Results: _____
Height: _____ Weight: _____ Are you in good health?.....Yes ( ) No ( )

Do you have any history of major illness? Yes ( ) No ( ) Explain: _____
_____

Check any of the following medical conditions that you have been treated for:

___ Diabetes	___ High blood pressure	___ Hormone Disorder	___ Sinus Infection	___ Rheumatic Fever
___ Anemia	___ Emotional Problems	___ Bone Disorders	___ Convulsions	___ Joint Replacement
___ Epilepsy	___ Fainting/Dizziness	___ Hepatitis	___ Allergies	___ Heart Trouble
___ Headaches	___ Bleeding Disorders	___ Arthritis	___ Venereal Disease	___ Heart Murmur
___ AIDS/HIV+	___ Ear Infection	___ Cancer	___ Asthma-Hay Fever	___ Congenital Heart Defect

Do you vomit, gag, or faint easily?.....Yes ( ) No ( )
Do you have a tendency to colds? ____ Sore throats? ____ Ear Infections? ____
Have tonsils and adenoids been removed?.....Yes ( ) No ( )
List and allergies or drug sensitivity: _____
List any drug or medications now being taken. Give reasons: _____
_____

DENTAL HISTORY

Why did you come to the orthodontist today? _____
Have any teeth been injured due to accidents or falls?.....Yes ( ) No ( )
Have you had any severe head, neck, or facial injuries?.....Yes ( ) No ( )
Give details of injuries: _____
Have you ever sucked a thumb or finger?.....Yes ( ) No ( )
Do you have any speech problems?.....Yes ( ) No ( )
Are you a mouth breather?.....Yes ( ) No ( )
Do you experience headaches or pain in or around the ears?.....Yes ( ) No ( )
Do you grind your teeth?.....Yes ( ) No ( )
Do you experience grating or popping noises in the jaw joints?.....Yes ( ) No ( )
When did you last have dental care? _____ Next visit: _____
Do you brush your teeth in the morning? _____ After lunch? _____ Before retiring? _____
Have you ever had any deciduous (baby) or permanent teeth removed?.....Yes ( ) No ( )
Has anyone in the family had orthodontic treatment?.....Yes ( ) No ( )

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status. I also authorize the orthodontic staff to perform necessary services that I may need.

SIGNATURE _____ DATE _____

E-Mail Address:_____

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