CASTLE PINES
ORTHODONTICS
Andrew J. Dunbar DDS, MS, PC

www.castlepinesortho.com
303-688-3837

PATIENT HISTORY INFORMATION

Welcome to our office

Date _____

Patients Name _____ Nickname _____

Date of Birth _____ Age _____ Grade _____ ☐ Male ☐ Female

Home Address _____ City _____ Zip _____

Home Phone _____ School _____

Name of Dentist _____ Who can we thank for your referral? _____

Information for patients who are minors:

Child's Hobbies _____

Sibling's Names & Ages _____

☐ FATHER ☐ STEP FATHER ☐ GUARDIAN

Name _____

Address _____

_____

Cell Phone _____

Employer _____

Business Phone _____

E-mail _____

Date of Birth_____

☐ MOTHER ☐ STEP MOTHER ☐ GUARDIAN

Name _____

Address _____

_____

Cell Phone _____

Employer _____

Business Phone _____

E-mail _____

Date of Birth_____

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Information for adult patients:

Occupation _____ Business Phone _____ Cell Phone _____

Employer _____ How long with this employer? _____

Name of Spouse _____ Spouse's Business Phone _____

E-mail _____ Date of Birth_____

Insurance Information:

Insured's Name _____ DOB _____ Insured's Soc.Sec.# _____

Insurance Company _____ Group # _____ Phone # _____

Insured's Employer _____

Do you have dual coverage? ☐ Yes ☐ No If yes, please continue

Insured's Name _____ DOB _____ Insured's Soc.Sec.# _____

Insurance Company _____ Group # _____ Phone # _____

Emergency Information:

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

MEDICAL HISTORY

Is the patient experiencing any health problems? ❑ Yes ❑ No Reason _____
Any major or unusual illnesses? ❑ Yes ❑ No Explain _____
Currently under physician's care? ❑ Yes ❑ No Reason _____
Currently taking medication? ❑ Yes ❑ No List _____
Drug sensitivity/allergies? ❑ Yes ❑ No List _____
Latex Allergy ❑ yes ❑ no Metal/Nickel Allergy ❑ yes ❑ no
Patient's Physician _____ Physician's Phone _____

Please check if Patient Has or Had any of the Following:

❑ Heart Murmur
❑ Has the patient ever been advised to take antibiotics prior to dental treatment?
❑ Anemia
❑ Heart disease
❑ Frequent colds or flu
❑ Blood Disease
❑ Tuberculosis
❑ Mouth breathing
❑ Prolonged bleeding
❑ Endocrine Problems
❑ Tonsillitis
❑ Diabetes
❑ Jaundice
❑ Tonsils Removed: Age _____
❑ Hepatitis
❑ Bone Disorders
❑ Adenoid or Sinus Infections
❑ Rheumatic Fever
❑ Asthma
❑ Adenoids Removed: Age _____
❑ Herpes
❑ Epilepsy/Seizure Disorder
❑ AIDS/AIDS Related Complex

Is there any possibility that the patient could be pregnant? ❑ Yes ❑ No
Adolescent females only: Has the patient started having menstrual cycles? ❑ Yes ❑ No When? _____

DENTAL HISTORY

Has the patient had any severe jaw or facial injuries? ❑ Yes ❑ No Explain _____
Has the patient had any injuries to teeth? ❑ Yes ❑ No Explain _____
Has the patient had a history of thumb of finger sucking? ❑ Yes ❑ No Explain _____
Has the patient consulted an orthodontist previously? ❑ Yes ❑ No
Are you satisfied with the prior treatment? ❑ Yes ❑ No

Has there ever been a history of:

❑ Clenching Teeth ❑ Muscular Soreness around head/neck ❑ Jaw Joint Soreness
❑ Grinding Teeth ❑ Excessive Headaches ❑ Jaw Joint Clicking ❑ Tongue Thrusting

Is there any other information that may be helpful? _____
Why are you seeking an orthodontic consultation? (What problems require correction?) _____
_____

Parent/Patient Signature_____ Date_____
Doctor Initials _____ Date _____