Date _____ *Dentist*_____

Joseph B Dankey, D.D.S

_____
Patient Number

"Smiles For a Lifetime"

Welcome to our office! Our specialty is creating smiles and caring for our patients. We appreciate you completing both sides of this Patient Information form.

Patient Name_____ _____
FIRST *MIDDLE Initial* *LAST* *COMMON NAME*

Address _____ _____ _____ _____
STREET *CITY* *STATE* *ZIP*

Birthdate _____ *Age* _____ *Phone* _____ *Email* _____

Marital Status _____ *Spouse's name* _____*How did you learn about our practice?* ____ *Internet* ____ *Ins Co*

___ *Dentist* ____ *Friend or Family - If so,* ***Who may we thank for referring you to our office*** _____

Current school _____ *grade* ___ *Favorite activites, sports or hobbies* _____

Have you visited our website at www.Broomfieldortho.com ____ *Yes* ____ *No*

Responsible party_____ *Relationship*_____

Address _____ _____ _____ _____
STREET *CITY* *STATE* *ZIP*

Birthdate _____ *Age* _____ *Phone* _____ *Email* _____

Preferred Method to be Contacted *phone#*_____ *text#*_____ *email address above*_____

Marrital Status _____ *Spouse's name* _____ *Phone* _____

Do you have Dental Insurance ___ *Yes* ___ *No If so, please complete the following*

Primary Insurance Co _____ *Employer* _____

Name of Insured _____ *Relationship to patient* _____

Insured's Birthdate _____ *Group #* _____ *SSN or ID #* _____

Secondary Insurance Co _____ *Employer* _____

Name of Insured _____ *Relationship to patient* _____

Insured's Birthdate _____ *Group #* _____ *SSN or ID #* _____

Emergency contact *Name*_____ *Relationship* _____*Phone*_____

Medical History

Are you currently under the care of an M.D. ___yes ___no Physicians name _____

Are you currently taking medication (including anti inflamatories) ___yes ___no If yes please list. _____

_____

Have you been in a serious accident, had severe head, jaw or facial injuries? ___yes ___no Explain _____

_____

Are there any medical conditions that you feel we should be aware of? _____

_____

Do you have any ***allergies?*** *(drugs, metal, latex, etc)* _____

Dental History

Dentist _____ *Date of last cleaning* _____

Chief concern about your teeth _____

Presently in any dental pain? ___yes ___no *Have you had any teeth removed?* _____

Headaches? ___ yes ___no *Clicking or popping in jaw? ___yes ___no*

Any soreness in face, neck or back? ___yes ___no *Bleeding gums? ___yes ___no*

Any thumb or tongue habits? ___yes ___no *Has anyone in your family had orthodontics? ___yes ___no*

Have you seen an orthodontist? ___yes ___no Are you aware that some appts will infringe on school or work time? ___yes ___no

Updates: *Has anything changed since you completed this form?*

		Signature	*Date*	*Changes*
Yes	*No*	_____	_____	_____
Yes	*No*	_____	_____	_____
Yes	*No*	_____	_____	_____

Conscent

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health and/or medication. Further, I will not hold my orthodontist, or any staff members responsible for any errors or ommisions that I have made on this form. ***I hereby assign to Joseph Dankey, DDS any and all orthodontic benefits otherwise payable to me for orthodontic treatment rendered by Joseph Dankey, DDS as described in the attached claim form.*** *I acknowledge that I am still responsible for paying the above reference orthodontist to the extent the relevent insurer or payor does not pay Joseph Dankey, DDS in full.*

_____ *Date* _____

Signature of Patient/Parent