



Dr. Jeffrey L. Collins • DDS, MSD

PATIENT INFORMATION

Patient's Name: _____ Sex: _____
Address: _____
Birth Date: _____ Age: _____ School if attending _____
If Patient is a minor, parent's or guardian's name _____
Best Phone # to reach you _____ E-mail _____
Who may we thank for referring you to our office? _____
General Dentist Name: _____ Date of last visit _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status _____
Address _____
Mailing address (if different from above) _____
E-Mail Address _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Social Security # _____ DOB _____ Relationship to Patient _____
Employer _____ Occupation _____ # Yrs. Employed _____
Spouse's Name _____ Relationship to Patient _____
E-mail Address _____
Employer _____ Occupation _____ # Yrs. Employed _____ DOB _____
Social Security # _____ Work # _____ Cell # _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ DOB _____
Insurance Co. Address _____ Phone # _____
Insured's Employer _____
Do you have dual coverage? [] Yes [] No If yes, please complete the information below:
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ DOB _____
Insurance Co. Address _____ Phone # _____
Insured's Employer _____

MEDICAL HISTORY

1. Please check if patient has or had any problems with the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Metal Allergy | <input type="checkbox"/> Gagging |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Earaches | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Endocrine (hormone) problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Women: Are you pregnant? |

2. Do you have any allergies or drug sensitivities? Yes No

If yes, to what? _____

3. Have you had rheumatic fever, congenital heart lesions, of damaged artificial heart valves? Yes No

If yes, what? _____

4. Do you have a heart murmur? Yes No

5. Do you take antibiotic premedication when you see a dentist? Yes No

If yes, what kind _____

6. Is there any condition affecting the patient's health other than those mentioned? Yes No

If yes, list _____

7. Do you take any medications for osteoporosis such as Fosamax, Boniva or Actonel Yes No

If yes, list _____

DENTAL HISTORY

8. Please check if the patient has or had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Clenching/grinding teeth | <input type="checkbox"/> Missing or Extra teeth | <input type="checkbox"/> Periodontal (gum) disease |
| <input type="checkbox"/> Jaw Joint problems | <input type="checkbox"/> Thumb or Finger sucking | <input type="checkbox"/> Tongue Thrust/Speech problems |

9. Does the patient have more than normal headaches or earaches? Yes No

10. Has the patient received previous orthodontic treatment? Yes No

11. Has anyone in your family had orthodontic treatment? Yes No Whom? _____

12. Please list sibling's names and ages _____

13. Would the patient be willing to wear braces if necessary to correct the problem? _____

14. Is there any reason why treatment should not be started immediately? _____

15. What is the primary reason for seeing an orthodontist? _____

EMERGENCY INFORMATION

Name of nearest relative not living with you. _____ Relationship _____

Complete Address _____ Phone # _____

I understand that it is my responsibility to keep this medical history updated throughout treatment.

I acknowledge that the above information is true and accurate.

Signature

Date

WELCOME

My Name is...

But, you can call me...

*I play...
(sport or instrument)*

Braces would be...

My friends...

come here for their braces too!

*I have a pet.
It's a...*

and I call it...

My hobbies are...

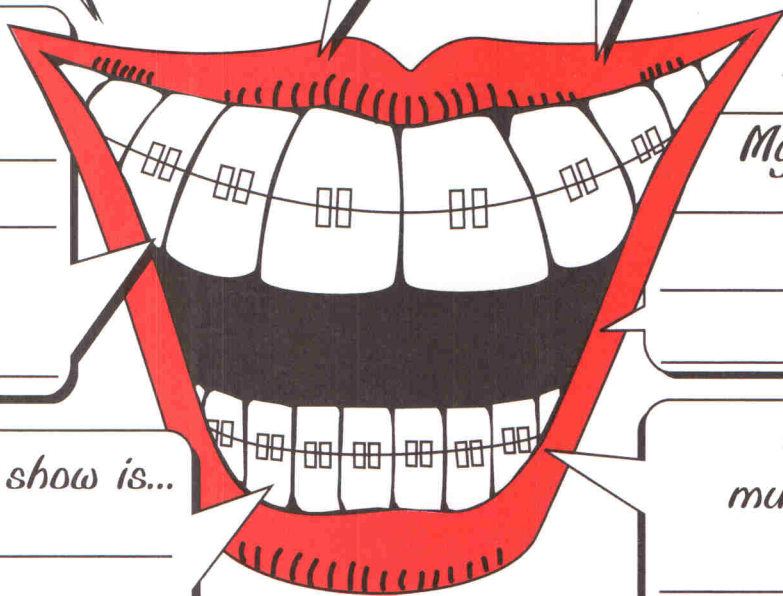
My favorite T.V. show is...

and I like to read...

My favorite music group is...

I wish I could...

*The greatest thing happened to me
and it was...*



*Our patients become our friends!
We are not only here to serve you
and provide you with excellent
orthodontic care but want you to
enjoy your experience with us.
Please help us get to know you
by telling us about yourself...*

*Thanks,
Dr. Jeffrey Collins and Staff!*



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WHY OVER **8000** PATIENTS HAVE CHOSEN A "DR. COLLINS' SMILE"

Experience: Dr. Collins has been serving the Parker area for over 20 years. Dr. Collins and Team have more than 200 combined years of orthodontic care.

Technology: Using the latest technology, our patients are assured the best results, more comfort and less treatment time.

Environment: Our beautiful office includes many amenities to make your visits more comfortable and fun, such as digital music, a video arcade, movies, etc. Our knowledgeable, caring team is readily available for all your needs.

Individuality: Working closely with each patient, we specialize the treatment plan to fit your specific concerns and wishes.

24/7 Access: On line access for up to date information on the patients account, appointments, financial history, contests and activities.

Consistency: You will see Dr. Collins at each visit and the same smiling faces to care for your needs.

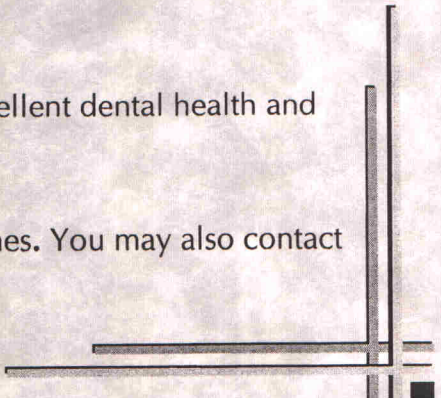
Testimonial: The majority of our patients have been referred to our office by their dentist, friends, and/or family members. In fact Dr. Collins has treated the children of many dental colleagues.

Best of the Best: Dr. Collins has been honored with Best of the Best every year since 2000 and is recognized by 5280 Magazine as one of Denver's top orthodontists.

Convenience: 3 locations including Elizabeth and Castle Rock, with our Parker office open 5 days a week for all your orthodontic needs.

Results: A BEAUTIFUL SMILE to last a lifetime, helping to ensure excellent dental health and facial harmony.

Availability: Dr. Collins or one of his assistants are available at all times. You may also contact us at braceit4u@aol.com.



WELCOME TO PARKER ORTHODONTICS

Thank you for choosing our office. We have enclosed a patient information sheet, please complete it and bring along to your appointment. This enables us to get to know you better and helps the appointment move along in a timely manner.

LOOKING FORWARD TO MEETING YOU!!

Dr. Jeffrey L. Collins and Staff

***If you have orthodontic insurance you would like us to check on, please bring an insurance card or general information.