. DR. COLIN GIBSON DDS, MS
2761 W 120th Ave #110
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#_____

****Mobile phone #** _____****Mobile Carrier**_____

****E-mail** _____

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 _____

Names of other siblings? _____

RESPONSIBLE PARTY INFORMATION

Name _____

Last First Middle Suffix/Title

Home Address_____

****E-mail** _____ ****Mobile phone #** _____

Social Security # _____ Date of Birth _____ Relationship to patient _____

Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION

Policy holder's Name _____ DOB: _____****Policy Holder's SS #** _____

Employer_____ Policy Holder Addr. _____

Insurance Co. _____ Group# _____ID#_____

Insurance Co. Add. _____ Phone No. _____

Does your job offer a "Flexible spending" account? Yes____ No____ Don't know____ Renewal Date? _____

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MEDICAL HISTORY OF NEW PATIENT

Patient's Name _____

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? _____

Female patients only:
Yes No Are you pregnant? _____

DENTAL HISTORY OF NEW PATIENT

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

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