Bridger Orthodontics
1039 Stoneridge Dr. Ste 2 Bozeman, MT 59718
406.551.2690
info@bridgerortho.com

NEW PATIENT FORM

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____ Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ Patient Birthdate: ____/____/____ ☐ Male ☐ Female

Patient Home Address: _____ City: _____ State: _____ Zip: _____

School: _____ General Dentist: _____

Family Members We Treat: _____ Primary Language: _____ Secondary Language: _____

2. DENTAL HISTORY

Does the patient have any of the following dental issues?

Cavities Bleeding Gums Bad Breath

☐ Congestion ☐ Mouth Breathing

Does the patient have any pain in the jaw joint (TMJ/TMD)? Yes No

Have there been any injuries to the teeth, face, or mouth? Yes No

If yes, pleases explain: _____

Does the patient currently have or had any of the following habits?

☐ Lip Biting ☐ Nail Biting ☐ Bottle Habits

☐ Tongue Thrust ☐ Pacifier ☐ Thumb/Finger Sucking

How often does the patient brush his/her teeth? _____

How often does the patient floss? _____

MEDICAL HISTORY

Has the patient ever had any of the following conditions?

Abnormal Bleeding	ADD/ADHD	Allergy: _____	Asthma	Autism Spectrum Disorder
Blood disorder	Cancer	Congenital Birth Defects	Developmental Delays	Diabetes
Down Syndrome	Kidney / Liver Condition	Hepatitis	Hearing Impairment	Heart Condition
HIV / AIDS	Pregnancy	Reflux / GI Problems	Scarlet Fever	Seizures
Tuberculosis	None of the Above			

If any of the above conditions are checked or if you would like to discuss any other medical conditions, please explain: _____

Is the patient currently under the care of a physician? Yes No Physician: _____

Does the patient require antibiotics for dental procedures? Yes No

List all drugs/ supplements the patient is currently taking: _____

PARENT OR LEGAL GUARDIAN'S INFORMATION / PERSON RESPONSILE FOR ACCOUNT

Name: _____ **Relationship**: _____ **SSN:** _____

Address: _____ **Email Address:** _____

Marital Status: Single Married Divorced Widowed **Cell #:** _____

Employer: _____ **Position**: _____

SPOUSE OR OTHER LEGAL GUARDIAN'S INFORMATION (if different form Section #4)

Name: _____ **Relationship**: _____ **SSN:** _____

Address: _____ **Email Address:** _____

Marital Status: Single Married Divorced Widowed **Cell #:** _____

Employer: _____ **Position**: _____

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6 NON-LEGAL GUARDIAN ACCOMPANYING THE PATIENT TO THEIR APPOINTMENT

Important Note: The parent or legal guardian is required to provide consent for dental treatment. **The adult(s) who accompanies the patient is responsible for payment at the time of service.** If applicable, please provide non-legal guardian(s) information below to ensure the patient's safety.

Full Name: _____ Do you have legal custody of the patient? ☐ Yes ☐ No

Relationship: _____

Full Name: _____ Do you have legal custody of the patient? ☐ Yes ☐ No

Relationship: _____

7 PRIMARY DENTAL INSURANCE

Insurance Name: _____ Policy Owner's Name: _____

Insurance Address: _____ Relationship to Patient: _____

Insurance Phone # _____ Birthdate: _____

Subscriber ID#: _____ SSN: _____

Group #: _____ Employer: _____

8 SECONDARY DENTAL INSURANCE

Do you have dual coverage? ☐ Yes ☐ No Insurance Name: _____ Subscriber ID#: _____

9 PERMISSION TO PHOTOGRAPH

I hereby give permission to Bridger Orthodontics, its assigns, and legal representatives the right to use my/my child's photograph in all forms of media including our website (www.bridgerchildrensdentistry.com), for advertising, for publication, or any other lawful purposes. I waive the right to inspect or approve the finished product, which may be created in connection with them.

10 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the patient's medical record.

I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform the necessary dental services I/my child may need.

Signature of Patient / Guardian: _____ Relationship: _____