helm orthodontics
at green valley ranch

New Patient Profile

Dr. Nathan Helm
Board Certified Orthodontist

How did you learn about our Practice, or Who were you referred by? _____
What would you like to change about your smile? Or what is your main concern? _____
Have other family members been seen by Dr. Helm? ☐Yes ☐No If yes, list names: _____

Patient Information

Name: _____ ☐M ☐F
LAST FIRST MI (initial)
Nickname: _____ Birthdate: ____/_____/____ Age: _____
School: _____
Home #: _____ Cell #: _____
Address: _____
_____
CITY STATE ZIP
E-mail Address (print neatly):

Insurance Information

PRIMARY
Insurance Company: _____
Subscribers Name: _____
LAST FIRST MI (initial)
SSN/ID #: _____ Birthday: ____/____/_____

SECONDARY
Insurance Company: _____
Subscribers Name: _____
LAST FIRST MI (initial)
SSN/ID #: _____ Birthday: ____/____/_____

Do you have Colorado Medicaid? ☐Y ☐N Medicaid ID #: _____
*All insurances must be listed for an accurate estimate of benefits

Dental History

General Dentist: _____ How many years? _____
Last cleaning/exam: ____/____/____ Any needed dental work? ☐Y ☐N
Have you ever had an orthodontic consultation? ☐Y ☐N
Have there been any injuries to the face, mouth, teeth, or chin? ☐Y ☐N
Has there been pain/tenderness in the jaw joints (TMJ/TMD)? ☐Y ☐N
Have you been diagnosed with periodontal disease/bone loss? ☐Y ☐N
Do your gums bleed when brushing or flossing? ☐Y ☐N
Are there any thumb, finger, or tongue habits? ☐Y ☐N
Do you clench or grind your teeth? ☐Y ☐N

Responsible Party Information (If Applicable)

☐**Mother** ☐**Stepmother** ☐**Other**_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Do you have legal custody of the patient? ☐Y ☐N
Are you responsible for the patient's financial account? ☐Y ☐N
Name: _____
LAST FIRST MI (initial)
Birthdate: ___/___/____ SSN: ____-____-_____ DL#: _____
Employer: _____ Job Title: _____
Home #: _____ Cell #: _____
Home Address: _____
_____
CITY STATE ZIP
E-mail Address (print neatly): _____

☐**Father** ☐**Stepfather** ☐**Other**_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Do you have legal custody of the patient? ☐Y ☐N
Are you responsible for the patient's financial account? ☐Y ☐N
Name: _____
LAST FIRST MI (initial)
Birthdate: ___/___/____ SSN: ____-____-_____ DL#: _____
Employer: _____ Job Title: _____
Home #: _____ Cell #: _____
Home Address: _____
_____
CITY STATE ZIP
E-mail Address (print neatly): _____

Growth Indicators (only for patients under 16 years old)

Has puberty begun? (Girls – Has menstruation begun?) ☐Y ☐N
Has the patient's shoe size changed recently? ☐Y ☐N

Medical History

Do you have a physician? ☐Y ☐N Physician's Name: _____ Phone #: _____ Are you in good health? ☐Y ☐N
Are you taking any prescription or over-the-counter drugs? ☐Y ☐N If yes, please list: _____
Have you ever received Bisphosphonate treatment or other bone building medications? ☐Y ☐N If yes, type and date: _____
Are there any known allergies (medications, latex, metals, plastics, etc.) ☐Y ☐N Please list: _____
Do you smoke tobacco? ☐Y ☐N Do you smoke marijuana? ☐Y ☐N Frequency: _____
Have you had or do you have any of the following medical conditions?

Artificial Bones/Joints/Valves ☐Y ☐N	Eating Disorders ☐Y ☐N	Heart Disorders ☐Y ☐N	Psychiatric Problems ☐Y ☐N
Arthritis/Joint Pain ☐Y ☐N	Emotional Problems ☐Y ☐N	Hepatitis ☐Y ☐N	Snoring/Sleep Apnea ☐Y ☐N
Asthma/Respiratory Disease ☐Y ☐N	Endocrine Disorders ☐Y ☐N	High/Low Blood Pressure ☐Y ☐N	Speech Problems ☐Y ☐N
Blood Disorders ☐Y ☐N	Epilepsy/Seizures ☐Y ☐N	Hospitalized (Any Reason) ☐Y ☐N	Tuberculosis ☐Y ☐N
Bone Disorders/Osteoporosis ☐Y ☐N	Fever Blisters/Herpes ☐Y ☐N	Kidney Disorders ☐Y ☐N	Thyroid Disorders ☐Y ☐N
Cancer/Tumors ☐Y ☐N	Gastric Reflux/GERD ☐Y ☐N	Learning Disabilities ☐Y ☐N	Vision Impairment ☐Y ☐N
Chemo/Radiation Therapy ☐Y ☐N	Growth Abnormalities ☐Y ☐N	Liver Disorders ☐Y ☐N	Require pre-medication before
Craniofacial Syndromes ☐Y ☐N	HIV+/AIDS ☐Y ☐N	Nervous Disorders ☐Y ☐N	dental procedures? ☐Y ☐N
Diabetes ☐Y ☐N	Hearing Impairment ☐Y ☐N	Pregnant (currently) ☐Y ☐N	Other: _____

If yes to any of the above, please explain: _____
Are there ANY behavioral or emotional conditions or problems that Dr. Helm should be aware of to better serve your child?
☐ADHD/ADD ☐PDD ☐Autism Spectrum Disorder ☐Anxiety Disorder ☐Sensory Disorder ☐Other: _____

*Please discuss with Dr. Helm any family circumstances, school situations, medical or psychological problems not covered above that may affect treatment

Authorization

-The information above is truthful and correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in medical/dental history.

-I authorize release of any medical/dental records to my dentist, dental specialists, healthcare providers, or dental insurance company. This may include transmittal of photographs/x-rays via email.

-I authorize Dr. Helm and his staff to perform the procedures necessary to complete a thorough orthodontic examination.

_____ _____
SIGNATURE OF PATIENT (If 18 years or older) or RESPONISBLE PARTY DATE

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