R. Scott Anderson, DMD

Creekside ORTHODONTICS
we make you smile

Tell us about yourself

Today's Date _____ Gender _____

Patient's Name _____
Last First MI

Nickname _____

Birthdate _____

Home Address _____
Street City State Zip

Mailing Address, if different _____

_____

Cell Phone _____ Home Phone _____

Email _____

SSN _____ DL# _____

Employer _____

Work Phone _____ Ext _____

How long at current job _____ Job title _____

General Dentist _____

Date of last visit _____

Emergency Contact Info

Name _____ Relationship _____

Address _____

Phone _____

Primary Dental Insurance

Insurance Carrier _____

Policy Owner's Name _____

Contact Number _____

Relationship to patient _____

Policy Owner's Birthdate _____

Policy Owner's ID / SSN _____

Group Number _____

Employer _____

Secondary Dental Insurance

Insurance Carrier _____

Policy Owner's Name _____

Contact Number _____

Relationship to patient _____

Policy Owner's Birthdate _____

Policy Owner's ID / SSN _____

Group Number _____

Employer _____

Chief Complaint

What are the main concerns that you would like to discuss at today's evaluation?

_____

_____

Dental History

YES	NO		
☐	☐	Do you currently suck thumb or fingers?	
☐	☐	Do you breathe predominately through their mouth?	
☐	☐	Does patient clench or grind teeth?	☐ at night ☐ day
☐	☐	Pain or noise in jaw joints?	
☐	☐	Teeth injured or chipped? When? _____	
☐	☐	Difficulty chewing or swallowing food?	
☐	☐	Severe head or face injuries?	
☐	☐	Have you been informed of any missing or extra teeth?	
☐	☐	Has a dentist ever placed a retainer or space maintainer?	
☐	☐	Have any teeth been removed by extraction?	

YES	NO	
☐	☐	Has a family member had orthodontic treatment? If so, who? _____
☐	☐	Have you had any previous orthodontic treatment?
☐	☐	Would you mind wearing braces?
☐	☐	Are there any other medical or dental problems I should be aware of? _____

Medical History

Physician _____

Name Street Address City Phone

YES NO

- ☐ ☐ Have you undergone a complete physical during the last year?
- ☐ ☐ Are you allergic to novocaine or any antibiotics like Penicillin or Erythromycin?
- ☐ ☐ Have you had an unusual reaction to Aspirin, Ibuprofen, Tylenol, or Codeine?
- ☐ ☐ Have you had any unusual reaction to any medication?
- ☐ ☐ Are you allergic to anything else? If so, what? _____
- ☐ ☐ Are you taking any medication? If so, what? _____
- ☐ ☐ Have you had tonsils and/or adenoids removed? If so, when? _____
- ☐ ☐ Have you ever been hospitalized? If so, when? _____

Have you had any of the following?

YES NO

- ☐ ☐ Chronic breathing or sinus problems
- ☐ ☐ Now under a physician's care
- ☐ ☐ High or low blood pressure
- ☐ ☐ Kidney disease or stones
- ☐ ☐ Asthma, emphysema, bronchitis
- ☐ ☐ Tuberculosis
- ☐ ☐ Frequent hives or skin rash
- ☐ ☐ Venereal disease
- ☐ ☐ Rheumatic fever
- ☐ ☐ ADD/ ADHD

YES NO

- ☐ ☐ Exposure to AIDS or HIV
- ☐ ☐ Congenital or other heart disease
- ☐ ☐ Abnormal bleeding after surgery
- ☐ ☐ Heart attack/open heart surgery
- ☐ ☐ Bruise easily
- ☐ ☐ Chest pains, arteriosclerosis
- ☐ ☐ Hemophilia, anemia, sickle cell
- ☐ ☐ Prosthetic joint surgery
- ☐ ☐ Shortness of breath

YES NO

- ☐ ☐ Cancer, previous or current
- ☐ ☐ Radiation treatment for tumor
- ☐ ☐ Seizures, epilepsy, fainting
- ☐ ☐ Thyroid disease or goiter
- ☐ ☐ Diabetes or high blood sugar
- ☐ ☐ Problems with anesthesia
- ☐ ☐ Arthritis or joint pain
- ☐ ☐ Problems with surgery
- ☐ ☐ Blood transfusions
- ☐ ☐ Hepatitis A, B, or C

Are you taking or have you taken any of the following?

YES NO

- ☐ ☐ Anticoagulants (blood thinners)
- ☐ ☐ Blood pressure medication
- ☐ ☐ Hormones
- ☐ ☐ Phen Fen, Redux, or any other prescription weight loss drug
- ☐ ☐ Fosamax, Boniva or any other drug for osteoporosis

YES NO

- ☐ ☐ Tranquilizers
- ☐ ☐ Insulin
- ☐ ☐ Heart drugs (nitroglycerin)
- ☐ ☐ Cortisone (steroids)
- ☐ ☐ Thyroid medication

Females Only:

Has menstruation begun? If so, date of onset? _____

Are you pregnant? **Y** **N** If so, when is your due date? _____

Are you currently taking oral contraceptive (birth control)? *Asking for jaw joint reasons **Y** **N**

Consent

With your permission we may take some diagnostic images (x-rays and photographs) at your initial visit so that we may better evaluate your needs. These are for internal use only and there will be no charge for these at this time. If your choose to have treatment or wish to take the images for use outside our office we will charge our normal fees for these images.

_____

Signature of Patient

In requesting examination and treatment, I authorize the release of all information, including radiographs, relating to the examination of treatment and to insurance companies. I also authorize the release of such information to any peer review or committee or state or local dental association which may request it. Complimentary radiographs will be taken at time of exam and will only be billed if treatment is elected or if radiographs are released from office.

I hereby authorize payment directly to Creekside Orthodontics or their associate the group insurance benefits otherwise payable to me, but not to exceed the actual charge for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

I understand that where appropriate, credit bureau reports may be obtained:

_____ _____

Print name and relationship **Signature of Patient** **Date**