R. Scott Anderson, DMD

Creekside ORTHODONTICS
we make you smile

Tell us about your child

Today's Date _____ Gender _____

Patient's Name _____
Last First MI

Nickname _____ SSN _____

Birthdate _____ Age _____

School _____ Grade _____

Home Address _____
Street City State Zip

Mailing Address, if different _____

_____

Cell Phone _____ Home Phone _____

Email _____

How did you learn of our office? (check all that apply)
☐ Dentist ☐ Friend/Family ☐ Google ☐ Facebook ☐ Yelp ☐ Other

General Dentist _____

Date of last visit _____

If patient is a minor:
Do you have legal custody of this child? ☐ Yes ☐ No

Name _____ Relationship _____

List brothers / sisters with ages _____

_____

Responsible Party

Name _____ Relationship _____

Billing Address _____
Street City State Zip

Cell Phone _____ Home Phone _____

SSN _____ DL# _____

Employer _____

Work Phone _____ Ext _____

How long at current job _____ Job title _____

Emergency Contact Info

Name _____ Relationship _____

Address _____

Phone _____

Parent(s)

Parent #1 Information ☐ Step Mother ☐ Guardian

Name _____ Birthdate _____

Cell Phone _____ Work Phone _____ Ext _____

SSN _____ DL# _____

Parent #2 Information ☐ Step Father ☐ Guardian

Name _____ Birthdate _____

Cell Phone _____ Work Phone _____ Ext _____

SSN _____ DL# _____

Home Address If Different

_____
Street City State Zip

Parents' marital status
☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

Primary Insurance

Dental coverage? ☐ Yes ☐ No Ortho coverage? ☐ Yes ☐ No

Insurance Carrier _____

Insurance Phone Number _____

Policy Owner's Name _____

Relationship to patient _____

Policy Owner's Birthdate _____

Policy Owner's ID / SSN _____

Group Number _____

Employer _____

Secondary Insurance

Dental coverage? ☐ Yes ☐ No Ortho coverage? ☐ Yes ☐ No

Insurance Carrier _____

Insurance Phone Number _____

Policy Owner's Name _____

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

- ☐ ☐ Does patient currently suck thumb or fingers?
- ☐ ☐ Does patient 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?
- ☐ ☐ Patient 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? _____
- ☐ ☐ Has patient had any previous orthodontic treatment?
- ☐ ☐ Would patient mind wearing braces?
- ☐ ☐ Has patient had a previous orthodontic consultation?
- ☐ ☐ Has patient ever been teased about the appearance of their teeth?
- ☐ ☐ Does patient want his/her teeth straightened?
- ☐ ☐ Are there any other medical or dental problems I should be aware of? _____

Medical History

Physician _____
Name Street Address City Phone

YES NO

- ☐ ☐ Has patient undergone a complete physical during the last year?
- ☐ ☐ Is patient allergic to novocaine or any antibiotics like Penicillin or Erythromycin?
- ☐ ☐ Has patient had an unusual reaction to Aspirin, Ibuprofen, Tylenol, or Codeine?
- ☐ ☐ Has patient had any unusual reaction to any medication?
- ☐ ☐ Is patient allergic to anything else? If so, what? _____
- ☐ ☐ Is patient taking any medication? If so, what? _____
- ☐ ☐ Has patient had tonsils and/or adenoids removed? If so, when? _____
- ☐ ☐ Has puberty begun?
- ☐ ☐ Has menstruation begun (girls)? If so, date of onset? _____

Has your child 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
- ☐ ☐ Shortness of breath after mild exercise

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
- ☐ ☐ Has patient ever been hospitalized?
- ☐ ☐ Hepatitis A, B, or C

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
- ☐ ☐ ADD/ ADHD

Is your child taking or have they taken any of the following?

YES NO

- ☐ ☐ Anticoagulants (blood thinners)
- ☐ ☐ Blood pressure medication
- ☐ ☐ Hormones (including birth control)
- ☐ ☐ 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

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 Parent or Guardian

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 Parent or Guardian** **Date**