Office Use Only:

REF BY: _____

DDS: _____

MRR? _____

ADVANCED ORTHODONTIC CARE
Robert T Rudman DDS, MS
ORTHODONTICS FOR CHILDREN & ADULTS
Discover your Smile

4500 Cherry Creek Drive South #850, Denver 80246 • 303.331.0222 • FAX 303.370.0124 www.advancedorthodonticcare.com

PLEASE PRINT ***TODAYS DATE: _____***

Home Email Address: _____

Patient Name	Nickname	Sex	Age
Birthdate:		Home Phone	
Address			
City	State	Zip	
Dentist	Physician		
How did you hear about our office?		Have you or a family member ever met Dr. Rudman?	
What questions would you like answered today?			

COMPLETE **FOR A CHILD PATIENT:**

School	Grade	Musical Instrument	
Sports	Hobbies/Interests		
Father's Name	Home Phone	Work Phone	
Address	City	State	Zip
Employer	Position		
Mother's Name	Home Phone	Work Phone	
Address	City	State	Zip
Employer	Position		

Siblings and Ages:

COMPLETE FOR AN ADULT PATIENT:

Your Employer Position	Work Phone	
Spouse's Name	Employer	Work Phone

DENTAL INSURANCE INFORMATION: (Please use information from your insurance card to complete this section)

Primary	**Secondary**
Ins. Co.	Ins. Co.
Address	Address
City/St./Zip	City/St./Zip
Phone#	Phone#
Insured Name	Insured Name
SS# - - D.O.B.	SS# - - D.O.B.
Group#	Group#
Employer	Employer
Person(s) responsible for payment & relationship to patient:	

MEDICAL HISTORY DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

<> AIDS	<> Diabetes	<> HIV Infection
<> Anemia	<> Emotional Problems	<> Kidney Disorders
<> Arthritis	<> Endocrine Disorders	<> Latex Sensitivity
<> Artificial Heart Valve	<> Epilepsy (Convulsions)	<> Liver Disease
<> Artificial Joints	<> Frequent Headaches	<> Mitral Valve Prolapse
<> Asthma	<> Glaucoma	<> Neurologic Disorders
<> Blood Disorders	<> Heart Murmur/Heart Problems	<> Respiratory Problems
<> Blood Transfusions	<> Hemophilia	<> Rheumatic Fever
<> Bruise Easily	<> Hepatitis	<> Thyroid Problems
<> Cerebral Palsy	<> Herpes	<> Tonsil or Adenoid Removal
<> Congenital Heart Disease	<> High Blood Pressure	<> Tuberculosis
<> Bisphosphonate <> Have taken <> Currently taking	<> Cancer_____	OTHER:

ALLERGIES - DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

<> Aspirin	<> Dental Anesthetic	<> Penicillin
<> Codeine	<> Erythromycin	<> Tetracycline
<> Metals/Plastic	<> Latex	

OTHER:_____

STATE ANY REASONS WHY THE PATIENT IS CURRENTLY UNDER THE CARE OF A PHYSICIAN

_____

HAS PATIENT REACHED PUBERTY?

LIST ANY MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING _____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES _____

HAS THE PATIENT BEEN ADVISED THAT ANTIBIOTICS SHOULD BE TAKEN PRIOR TO DENTAL PROCEDURES? (YES OR NO)

LIST ANY OTHER SERIOUS ILLNESSES, OPERATIONS OR DISEASES NOT LISTED ABOVE _____

DENTAL HISTORY DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

<> Bleeding Gums	<> Jaw Joint Pain	<> Nail Biting
<> Chronic Facial Pain	<> Jaw Joints Pop or Click	<> Periodontal Surgery
<> Clenching or Grinding of Teeth	<> Jaw Locking Open or Closed	<> Permanent Teeth Removed
<> Difficulty Chewing or Swallowing	<> Limitation in Mouth Opening	<> Speech Problems
<> Dizziness	<> Missing or Extra Permanent Teeth	<> Sucks Thumb, Finger or Lip
<> Frequent Headaches	<> Mouth Breathing	<> Teeth Sensitivity - Hot/Cold
<> Injuries to Face or Teeth	<> Muscle Tenderness in Jaw or Neck	<> Tongue Thrust

DATE OF LAST DENTAL VISIT_____

LIST THE PATIENT'S CHIEF CONCERNS AND WHAT THEY WOULD LIKE THIS ORTHODONTIC TREATMENT TO ACCOMPLISH

_____

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status. I authorize release of any information to insurance carriers and to other health care providers involved in my child's care. I authorize Dr. Robert Rudman and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment. I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____ DATE_____

PLEASE PRINT THIS FORM AND BRING WITH YOU TO YOUR APPOINTMENT