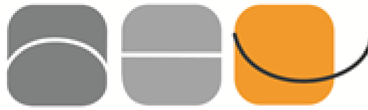
Office Use Only
IN: ________________
WOD: _______________
DRR:
____



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

Office Use Only:
REF BY:
DDS:
MRR?

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

Date: ____________________

Email Address: ____

Patient First and Last Name | Nickname | Sex/Pronouns: | Age

Birthdate: | Cell/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 or Dr. Birg?

What questions would you like answered today?

COMPLETE **FOR A CHILD PATIENT:**

School | Grade | Musical Instrument

Sports | Hobbies/Interests

Father's/Mother's Name | Home Phone | Work Phone

Address | City | State | Zip

Employer | Position

Father's/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#	
Policy Holder:		Policy Holder:	
SS#	D.O.B.	SS#	D.O.B.
Member ID:		Member ID:	
Employer		Employer	

Person(s) responsible for payment & relationship to patient:

ANY DENTAL ANXIETY? **NONE** **MILD** **MODERATE** **SEVERE**

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______________