



# Smiles Hollywood Style Orthodontics™

Where Our Patients are the Stars!™

Stephanie Crise DDS, MS Jessica Downs DDS, MS  
Specialists in Orthodontics for Children & Adults

## Acquaintance Record-Youth

Patient's Name \_\_\_\_\_ Sex \_\_\_\_\_ Nickname \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_ School \_\_\_\_\_

List any hobbies, sports or school activities enjoyed: \_\_\_\_\_

List names & ages of any siblings: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

### Medical History/Information

Please indicate YES if the Patient currently has or has ever had any of the following medical conditions.

	Yes	No		Yes	No		Yes	No
Heart Disease?			Asthma or Hay Fever?			Nervous/Emotional Problems?		
Heart Murmur or Defect?			Tuberculosis?			High or Low Blood Pressure?		
Respiratory Disease?			Any Broken Bones?			Problems with Wound Healing?		
Blood Disease?			Prolonged Bleeding?			Chemotherapy?		
Liver Disease?			Yellow Jaundice?			Osteoporosis?		
Thyroid Disease?			Radiation Therapy?			Rheumatic/Scarlet Fever?		
Kidney Disease?			Mononucleosis?			Rheumatism or Arthritis?		
Venereal Disease?			Hepatitis?			Is Patient Currently Under Medical Care?		
Intestinal Disease?			Polio?			History of Fainting or Dizziness?		
Bone Disease?			Diabetes?			Presence of Drug / Alcohol Addiction?		
Endocrine Problems?			Anemia?			Is the Patient Pregnant at This Time?		
HIV Positive?			Hemophilia?			Does the Patient Smoke?		
Blood Transfusion?			Emphysema?			Has Patient Ever Had Fever Blisters?		
Tumors or Cancer?			Epilepsy or Seizures?			Is the Patient in Good Health?		

If Female, Has Menstruation Begun? Yes / No

If Yes, When Did it Start?

Is the Patient Allergic to Anything?

Yes No

If Yes, Please list all allergies. (penicillin, latex, medicines, foods)

Is the Patient Currently Taking Any Medications?

Yes No

If Yes, Please list all medications.

Are You Aware of Any Other Disease, Condition, or Disability Not Listed Above?

Yes No

If Yes, Please list/explain.

### Dental History

Patient's Dentist :

Date Last Seen:

Any Pain, Clicking or Discomfort In or Near the Ears? Yes / No

Any Severe or Frequent Headaches?

Yes No

Has/Have the Mouth, Face or Teeth Been Injured by a Fall or Accident?

Yes No

Have You Been Informed of Missing or Extra Permanent Teeth?

Yes No

Are You Aware of Any "Gum" Problems? Yes / No

Has the Patient Had Any Periodontal "Gum" Treatment?

Yes No

Has a Physician or Dentist Advised Antibiotics Before a Dental Exam?

Yes No

Have the Patient's Tonsils or Adenoids Been Removed? Yes / No

If Yes, When?

Do You Feel the Patient Can Benefit From Orthodontic Treatment?

Yes No

Does the Patient Want to Improve His/Her "Smile" and/or "Bite"?

Yes No

Would the Patient mind wearing braces?

Yes No

Has the Patient Been Examined by an Orthodontist Before? Yes / No

If Yes, When?

Have Other Family Members Had Orthodontic Treatment? Yes / No  
Why?

If Yes, Were you happy with results?

If Not,

What Is Your Chief Orthodontic Concern for the Patient?

## Parent/Guardian Information

Father or Guardian:	Name:	Home Phone:
	Address:	City / Zip:
	Employer:	Work Phone:
	Social Security # :	DOB:

Mother or Guardian:	Name:	Home Phone:
	Address:	City / Zip:
	Employer:	Work Phone:
	Social Security # :	DOB:

Marital Status:    Single             Married             Divorced             Separated             Widowed

Parent/Guardian responsible for this account: \_\_\_\_\_

Address to use for correspondence: \_\_\_\_\_  
\_\_\_\_\_

## Insurance Information

1. Is there orthodontic insurance for this patient? \_\_\_\_\_  
If Yes, Is insurance provided by mother/father or guardian's employer? \_\_\_\_\_
2. What is the name of the insurance carrier? \_\_\_\_\_
3. Phone#: (1-8 - ) or \_\_\_\_\_ Group#: \_\_\_\_\_
4. Mailing Address: \_\_\_\_\_

## Authorization to Release Confidential Information for Insurance Purposes and Consent for Treatment

I, \_\_\_\_\_ authorize my insurance carrier to release benefit and/or claim information on  
Parent/Guardian/Responsible Party  
\_\_\_\_\_ to the office/staff of Smiles Hollywood Style Orthodontics™. This consent is effective  
Patient

until such date as I revoke consent in writing. I understand that information obtained as a result of this consent will be used only for its intended purpose and may be used after the cancellation date for claim information. A copy of this authorization should be accepted as valid as the original.

The undersigned, with prior information and approval, hereby authorize the doctors/staff of Smiles Hollywood Style Orthodontics™ to perform any and all forms of diagnosis, treatment, medication and/or therapy that may be indicated in the professional orthodontic care for \_\_\_\_\_.  
Patient

I further consent for my child's picture to be displayed on the clinic "Hall of Fame" wall.

\_\_\_\_\_  
Signature of Parent/Guardian/Responsible Party

\_\_\_\_\_  
Date

Signature above acknowledges agreement to above statements, terms and conditions contained herein.

