WELCOME TO THE ORTHODONTIST

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: ___/___/___ ☐ Male ☐ Female

Child's Name: ______________________ (LAST / FIRST / MI)

Nickname: ______________ SS#: ______________

Child's Birthdate: ___/___/___ Child's Age: ______________

School: ______________ Grade: ______________

Hobbies / Sports: ______________

Child's Home #: (___)______________

Child's Home Address: ______________ APT/CONDO #

______________ CITY / STATE / ZIP

E-Mail Address: ______________

2 Who Is Accompanying Your Child Today?

Name: ______________ Relation: ______________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? ______________

List brothers / sisters with age: ______________

____

General Dentist: ______________

Last Visit Date: ______________

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

3 Mother's Information: ☐ Step Mother ☐ Guardian

Name: ______________ Birthdate: ___/___/___

Wk #: (___)______________ Ext: _____ Hm #: (___)______________

Employer: ______________

How Long at Current Job: _______ Job Title: ______________

SS #: ______________ DL #: ______________

Father's Information: ☐ Step Father ☐ Guardian

Name: ______________ Birthdate: ___/___/___

Wk #: (___)______________ Ext: _____ Hm #: (___)______________

Employer: ______________

How Long at Current Job: _______ Job Title: ______________

SS #: ______________ DL #: ______________

4 Person Responsible For Account

Name: ______________ Relation: ______________

Billing Address: ______________

______________ CITY / STATE / ZIP

Previous Address: ______________

______________ CITY / STATE / ZIP

Hm #: (___)______________ DL #: ______________

Employer: ______________

Wk #: (___)______________ Ext: _____ SS #: ______________

Who is responsible for making appointments?

Name: ______________

Wk #: (___)______________ Ext: _____ Hm #: (___)______________

Neighbor or Relative not living with you.

Name: ______________ Phone: (___)______________

Address: ______________

______________ CITY / STATE / ZIP

5 Primary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: (___)______________

Group # (Plan, Local, or Policy #): ______________

Policy Owner's Name: ______________

Relationship to Patient: ______________

Policy Owner's Birthdate: ___/___/___ SS #: ______________

Policy Owner's Employer: ______________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: (___)______________

Group # (Plan, Local, or Policy #): ______________

Policy Owner's Name: ______________

Relationship to Patient: ______________

Policy Owner's Birthdate: ___/___/___ SS #: ______________

Policy Owner's Employer: ______________

CONTINUED ON BACK

What are the main concerns that you would like orthodontics to accomplish? ______________________

____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: ______________________

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: ______________________

Phone #: (____)____________ Date of Last Visit: __________

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If yes, when? __________________

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: __________

____

Please list all drugs/things that your child is allergic to: __________

____

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Allergies to any Drugs
Y N Allergic to Latex / Metals
Y N Allergic to Plastic
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+ / AIDS
Y N Kidney Problems
Y N Liver Problems
Y N Rheumatic / Scarlet Fever
Y N Sickle Cell Disease / Traits
Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

____

____

____

Does/did your child have any of the following habits?

Y N Clenching / Grinding Teeth
Y N Lip Sucking / Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb / Finger Sucking
Y N Tongue Thrust

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____

Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: Initials: __________ Date: __________

____

____

____

 © 2001 INFORMS, INC. 1-800-722-4884

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

____
Patient's Name

____
Name of Responsible Party

____
Signature of Responsible Party

____
Date

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- • To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);

- • To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

- • To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;

- • Internally, to all staff members who have any role in your treatment;

- • To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;

- • To your family and close friends involved in your treatment; and/or,

- • We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- • Request restrictions on the use and disclosure of your protected health information;
- • Request confidential communication of your protected health information;
- • Inspect and obtain copies of your protected health information through asking us;
- • Amend or modify your protected health information in certain circumstances;
- • Receive an accounting of certain disclosures made by us of your protected health information; and,

- •You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- •By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- •To abide by the terms of our Privacy Notice that is currently in effect;
- •To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- •Honor any request by you to restrict the use or disclosure of your protected health information;
- •Amend your protected health information if, for example, it is accurate and complete; or,
- •Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

______________________________ ______________________________

Patient's Name Date

____

Responsible Party's Name

____

Responsible Party's Signature