

Patient Information - Child or Teen

Patient's Name: _____ Sex: Male Female
First Last MI

Birthdate: _____ School: _____ Grade: _____

Patient's Home Phone: _____ Patient's Cell Phone: _____

Patient's Home Address: _____
Apt. #

City _____ State _____ Zip _____

Does the Child have an email for fun office updates? _____

How did you hear about our office? _____

Child's Family Dentist: _____

Have we treated another member of your family? YES NO If YES, Name(s) _____

PARENT OR GUARDIAN INFORMATION

Marital Status: Single Married Widowed Divorced Separated Domestic Partner

Mother's Name: _____ Birthdate: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Email Address: _____

Father's Name: _____ Birthdate: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Email Address: _____

Insurance Information

Insured's Employer: _____ Occupation _____

Insurance Company Name: _____ Insurance Company Phone: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's ID number: _____ Insured's Group Number: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers and confirm coverage.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Confirm appointment using voicemail, email, text messaging, postcards, or letters
- Disclose health information to a family member, friend, or caregiver to the extent necessary to help you with your healthcare.

I acknowledge that I have read and/or received the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare information. I also understand that you're not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Please Print

Name of Parent/ Guardian (if under 18): _____

Please Print

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (_____) _____

Your current physical health is:

Good Fair Poor

Are you currently under the care of a physician?

Yes No

Please explain: _____

Are you taking any prescription/over the counter drugs?

Yes No

Please list each one: _____

Do you have any sensitivities/allergies? Yes No

Please list each one: _____

For women:

Are you pregnant? Yes No

Are you nursing? Yes No

For growth assessment, has menstruation/period begun?

Yes No N/A

Have you ever had any of the following diseases or medical problems? (please circle)

- | | |
|-----------------------------|--------------------------|
| Allergies | Heart Disease/Stroke |
| Angina/Chest Pains | Heart Murmur/ Defect |
| Artificial Bones/Joints | Heart Surgery/ Pacemaker |
| Arthritis | HIV/ AIDS |
| Asthma | Hepatitis/ Liver Disease |
| Bleeding Disorder | Kidney Disease |
| Cancer/Chemotherapy | Mitral Valve Prolapse |
| Diabetes | Psychiatric Illness |
| Drug/Alcohol Abuse | Rheumatic/ Scarlet Fever |
| Ear Infections | Sinus Problems |
| Emphysema/ COPD | Tuberculosis |
| Epilepsy/ Seizures | Ulcers/ Colitis |
| Headaches - Severe/Frequent | Venereal Disease |

Has your physician/dentist recommended that you take antibiotics before dental treatment? Yes No

DENTAL HISTORY

Why are you seeking orthodontic treatment?

Do you like your smile? Yes No

Have you ever seen an orthodontist or received orthodontic treatment before? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/ TMD)? Yes No

Your current dental health is:

Good Fair Poor

General Dentist: _____

Last visit date: _____

Treatment rendered: _____

Have you ever been treated for periodontal disease?

Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? Yes No

Do you generally breathe through your mouth?

Awake? Yes No Asleep? Yes No

Do you have any missing or extra permanent teeth?

Yes No

Do you use any tobacco products? Yes No

I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature _____

Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the ADA, and the ISDS.

For Office Use Only:

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

Initials: _____ Date: _____