

# 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.

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## 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: \_\_\_\_\_

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## 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

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## 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 #: \_\_\_\_\_

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## 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

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## 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: \_\_\_\_\_



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?

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

Please discuss any medical problems that your child has had:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Clenching / Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking / Biting       | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather             | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb / Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting                | <input type="checkbox"/> Y <input type="checkbox"/> 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## 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.

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Patient's Name

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Name of Responsible Party

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Signature of Responsible Party

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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