PATIENT INFORMATION FORM

PATIENT DETAILS

Patient's First Name _____ Patient's Last Name _____ Nickname _____

Patient's Address _____ City _____ State _____ Zip _____

Interests/Sports/Hobbies _____ Gender _____ Home Phone _____

Date of Birth _____ Age _____ Race _____ Cell Phone _____

School/Employer _____ Grade/Position _____ Work Phone _____

How did you hear about our office _____ Patient's Email _____

Family members treated in our office _____

Reason for consultation _____

Dentist _____ Date of last cleaning _____

Has the patient been examined by an orthodontist before? ☐ Yes ☐ No

RESPONSIBLE PARTY / INSURANCE INFORMATION

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Stepparent ☐ Other (specify) _____

Guardian's First Name _____ Guardian's Last Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Date of Birth _____ Social Security Number _____ Cell Phone _____

OTHER INSURANCE (IF APPLICABLE): Guardian's E-Mail _____

Company Name _____ Phone _____ Subscriber/Member ID _____

RESPONSIBLEPARTY2 / INSURANCE INFORMATION

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Stepparent ☐ Other (specify) _____

Guardian's First Name _____ Guardian's Last Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Date of Birth _____ Social Security Number _____ Cell Phone _____

OTHER INSURANCE (IF APPLICABLE): Guardian's E-Mail _____

Company Name _____ Phone _____ Subscriber/Member ID _____

SLEEP / AIRWAY ISSUES

Does the patient tend to be a mouthbreather? ☐ Yes ☐ No

Does the patent seem rested in the morning? ☐ Yes ☐ No

Has the patient seen an Ear, Nose & Throat Specialist? ☐ Yes ☐ No

Does the patient snore at night? ☐ Yes ☐ No

Is the patient often sleepy during the day? ☐ Yes ☐ No

Is the patient using a sleep apnea device? ☐ Yes ☐ No

DENTAL/MEDICAL HISTORY

Please check if the patient has a history of the following medical conditions:

☐ Yes ☐ No ADHD/ADD	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No AIDS/HIV	☐ Yes ☐ No Down Syndrome	☐ Yes ☐ No Muscular Disorders
☐ Yes ☐ No Acid Reflux	☐ Yes ☐ No Ear Pain	☐ Yes ☐ No Nervous Disorders
☐ Yes ☐ No Anemia	☐ Yes ☐ No Emotional Disorders	☐ Yes ☐ No Organ Transplant
☐ Yes ☐ No Arthritis	☐ Yes ☐ No Endocrine Problems	☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Asthma	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Painful Chewing
☐ Yes ☐ No Autism	☐ Yes ☐ No Headaches	☐ Yes ☐ No Periodontal Problems
☐ Yes ☐ No Bone Disorders	☐ Yes ☐ No Heart Condition	☐ Yes ☐ No Prolonged Bleeding
☐ Yes ☐ No Cancer	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Cerebral Palsy	☐ Yes ☐ No Immune Problems	☐ Yes ☐ No Scoliosis
☐ Yes ☐ No Chest Pain	☐ Yes ☐ No Jaw Clicking	☐ Yes ☐ No Seizures
☐ Yes ☐ No Chronic Neck Pain	☐ Yes ☐ No Jaw Pain	☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Cold Sores/Herpes	☐ Yes ☐ No Kidney Problems	☐ Yes ☐ No TMJ Problems
		☐ Yes ☐ No Tuberculosis

☐ Yes ☐ No Do your gums bleed when you brush?
☐ Yes ☐ No Is the patient seeing any other dental specialists (e.g., periodontist)? _____
☐ Yes ☐ No Any dental restorations needing to be completed? What? _____
☐ Yes ☐ No Have there ever been any injuries to the face, mouth or chin? _____
☐ Yes ☐ No Have you ever lost or chipped any teeth? Which tooth/teeth? _____
☐ Yes ☐ No Do you have any pain or soreness around your face, neck or back? _____
☐ Yes ☐ No Is any part of your mouth sensitive to temperature or pressure? _____
☐ Yes ☐ No Is the patient currently pregnant? Due Date? _____
☐ Yes ☐ No Have adenoids been removed? If yes, when? _____
☐ Yes ☐ No Have tonsils been removed? If yes, when? _____
☐ Yes ☐ No Currently taking any medications? List. _____
☐ Yes ☐ No Are antibiotics necessary prior to treatment? List. _____
☐ Yes ☐ No Allergies (i.e., Drug, Latex, etc.) _____
☐ Yes ☐ No Any diseases or problems not mentioned above? List here.

_____

Please check if the patient has, or ever had, any of the following habits?

☐ Cheek, tongue or lip chewing ☐ Clenching teeth ☐ Finger nail biting ☐ Grinding teeth
☐ Tongue sucking ☐ Thumb sucking ☐ Tongue thrusting

SIGNED CONSENT

I understand the information given is correct and will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in the patient's medical status.

I hereby authorize this office to perform an orthodontic evaluation and consent to the taking of x-rays, photographs, and other records (if necessary) to determine appropriate treatment on the above-named patient.

I also authorize this office to leave messages about appointments on my voice mail or answering machine, and agree to receive e-mail reminders and text messages about appointments.

Typed Name/Signature _____ Relationship to Patient _____ Date _____

If someone other than the parent(s) or guardian(s) listed above will be bringing the patient to appointments, please list here:

_____

HIPAA Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a HIPAA or the Healthcare Privacy Act). I understand that by signing this consent, I authorize This Office to use and/ or disclose my protected healthcare information to carry out the following:

- Treatment which includes direct and/ or indirect treatment by my other healthcare providers involved in my treatment.

- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/ companies.

- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses of disclosures of my protected health information, and my rights under HIPAA. I understand that your reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do not agree, you are bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Patient Name_____ Date_____