

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 _____

RESPONSIBLE PARTY 2 / 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 patient 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:

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

- | | | | |
|-------------------------------------------------------|------------------------------------------|---------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Cheek, tongue or lip chewing | <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Finger nail biting | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Tongue sucking | <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> 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:

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 you 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 _____