Patient Information

PATIENT NAME | PATIENT'S D.O.B | AGE

NICKNAME | MALE | FEMALE | SS #

STREET ADDRESS, APT NO. | CITY | STATE | ZIP

PHONE# | CELL# | WORK# | EXT

Responsible Party Information

NAME | D.O.B. | RELATIONSHIP TO PATIENT

STREET ADDRESS, APT NO. | CITY | STATE | ZIP

PHONE# | CELL# | WORK# | EXT.

SS # | DRIVER'S LICENSE# & STATE ISSUED

E-MAIL ADDRESS

MARITAL STATUS: O SINGLE O MARRIED O DIVORCED O WIDOWED

DO YOU HAVE LEGAL CUSTODY? O YES O NO

IF NO, WHO IS THE LEGAL GUARDIAN?

Insurance Information

NAME OF POLICY HOLDER | POLICY HOLDER'S D.O.B.

POLICY HOLDER'S SS # | EMPLOYER | WORK#

NAME OF INSURANCE | GROUP# | ID#

INSURANCE ADDRESS | CITY | STATE | ZIP

INSURANCE PHONE# | RELATIONSHIP TO PATIENT

Secondary Insurance

NAME OF POLICY HOLDER | POLICY HOLDER'S D.O.B.

POLICY HOLDER'S SS # | EMPLOYER | WORK#

NAME OF INSURANCE | GROUP# | ID#

INSURANCE ADDRESS | CITY | STATE | ZIP

INSURANCE PHONE# | RELATIONSHIP TO PATIENT

Emergency Contact Information

NAME | PHONE# | CELL#

RELATION

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices

Notice to Patient or Responsible Party if Patient is a Minor: We are required to provide you with a copy of our notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

PRINT YOUR NAME

SIGNATURE | DATE

Patient Information

Medical Information: Please check Yes or No

A. Does the patient currently have or has the patient ever had any of the following:

	YES	NO
Heart Disease		
Respiratory Disease		
Blood Disease		
Liver Disease		
Thyroid Disease		
Kidney Disease		
Stomach Disease		
Venereal Disease		
Intestinal Disease		
Bone Disease		
Hearing Problems		
Nervous/Emotional Problems		
ADHD		
High or Low Blood Pressure		
Endocrine Problems		
Problems with Wounds Healing		
Night Sweats		
Weight Loss		
Anorexia		

	YES	NO
Fever		
Persistent cough		
Bloody sputum		
Tumors or cancer		
Rheumatic/yellow/scarlet fever		
Aids/HIV		
Rheumatism or arthritis		
Fainting or dizziness		
Measles/mumps/chicken pox		
Fever blisters		
Heart murmur		
Mononucleosis		
Hepatitis		
Polio		
Diabetes		
Anemia		
Hemophilia		
Emphysema		

	YES	NO
Epilepsy		
Asthma or hay fever		
Tuberculosis		
Broken bones		
Prolonged bleeding		
Yellow jaundice		
Radiation therapy		
Chemical therapy		
Blood transfusions		
Sinus problems		
Severe/frequent headaches		
Difficulty breathing		
Drug/alcohol abuse		
Any stays in the hospital? When/why?		
Other		

B. Is the patient allergic to:

	YES	NO
Aspirin		
Codeine		
Latex		
Erythromycin		
Penicillin		
Dental anesthetics		
Tetracycline		
Other List:		

Is the patient:

	YES	NO
Under the care of a doctor? What for? Doctor's name:		
Taking medication? List:		
in ❑ Good ❑ Fair ❑ Poor health?		

	YES	NO
Normal height/weight?		
Past puberty?		
Taking birth control pills?		
Pregnant? Week No. ______		
Currently smoking?		
Addicted to drugs/alcohol?		
Currently taking, or has the Patient ever taken, medications known as bisphosphonates?		
Seen by a physician routinely? Physician's name:		

C. Dental History – Has the patient:

	YES	NO
Seen his/her general dentist in the last six months?		
Had any pain, clicking, or discomfort in or near the ears?		
Been informed of missing or extra permanent teeth?		
Had mouth, face, or teeth injured by a fall or accident?		
Been told of any 'gum' problems?		
Had a physician or dentist prescribe antibiotics before a dental exam?		
Had tonsils or adenoids removed?		
Been examined by an orthodontist before? If so, when and by whom?		
Have other members of the family had orthodontic treatment? if yes, were they happy with the results?		
Had frequent headaches?		
Does the patient mind wearing braces?		

Has the patient ever had the following habits:

	YES	NO
Cheek, Tongue or Lip Chewing		
Sucks thumb/fingers		
Mouth breathing		
Teeth clenching		
Teeth grinding		
Tongue thrusting		
Speech problems		

____
Reviewed By

____
Date

Whom may we thank for referring you?
❑ General Dentist ❑ Friend ❑ Relative ❑ Patient
Their name:____

If not referred, how did you hear about us?
❑ Web Search ❑ TV ❑ Billboard ❑ Event ❑ Print ad ❑ Social Media
Other:____

The information that I have given is correct, to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my/my child's medical or dental status.

I request that the doctors and staff of Desert Orthodontics transfer manually and/or electronically all information related to payment for and treatment of my/my child's orthodontic case to other dentists, physicians, insurance companies, Medicaid programs, and support companies (i.e. custom appliance labs, computerized study model companies). Such reports may include, but are not limited to, medical, dental, and orthodontic care and treatment; illness or injury; dental and medical history; consultation; prescriptions; x-rays; photographs; models; and all copies of financial payment, dental, and medical records.

I also authorize the dental staff to perform the necessary dental services that I/my child may need during treatment.

______________________________ ____________
Signature of Patient/Legal Guardian Date