



Date _____ Date of Birth _____ Age _____ Height _____ SEX: M _____ F _____
 Name _____ (FIRST) _____ (MIDDLE) _____ (LAST) _____ Nickname _____
 Address _____ City _____ Zip _____
 Email _____ Cell Phone: Child _____ Cell Phone: Mom _____ Cell Phone: Dad _____
 Telephone: Home: _____ Work Phone: Mom _____ Work Phone: Dad _____
 Family Dentist _____ City _____ Phone _____
 Family Physician _____ City _____ Phone _____
 School _____ City _____ Grade _____
 Sports/Hobbies etc. _____

FAMILY HISTORY

Parents: Married _____ Divorced _____ Father Deceased _____
 Parents: Separated _____ Child lives with _____ Mother Deceased _____
 Father's Name _____ Occupation _____
 Employer's Name and Address _____ Social Security No. _____
 Dental Insurance: Name _____ Dad's Birthday (for insurance) _____
 Medical Insurance: Name _____
 Mother's Name _____ Occupation _____
 Employer's Name and Address _____ Social Security No. _____
 Dental Insurance: Name _____ Mom's Birthday (for insurance) _____
 Medical Insurance: Name _____
 Name and ages of brothers and sisters _____
 Other family members with similar dental conditions or orthodontic treatment (names and ages) _____
 If so, have we treated any of these family members? Yes _____ No _____
 Have you had any other experience with or seen another orthodontist? Yes _____ No _____ Name _____

MEDICAL DENTAL HISTORY

Injury or trauma to the face or teeth or birth defects _____
 Presently under medical care for _____
 Drugs or medication being taken now (drug and dose) _____
 Allergic to what medication _____
 Major reason for seeking treatment _____
 How did you first hear about our practice? _____
 Who may we thank for referring you to our practice? _____
 Please check yes or no to the following and date:

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
Adopted Child	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids (removed)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ear/Nose infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart disorder/murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tonsils (removed)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
												Other			_____

Do you require antibiotic premedication prior to dental appointments? If yes, which antibiotics do you usually take? _____

Please give us any additional information or details where necessary _____

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your health information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures, in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or healthcare professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PATIENT ACKNOWLEDGEMENT

Please sign this form below under the heading "acknowledgement" to acknowledge that you have received a copy of our Notice of Privacy Practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient/Responsible Party Signature

Patient Name (please print)

Date: _____

PATIENT CONSENT

Please sign this form below under the heading "Consent" to consent our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient/Responsible Party Signature

Patient Name (please print)

Date: _____

For office use only

Patient refused to sign

The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient from signing the Acknowledgement.

Office Personnel (signature)

Office Personnel (print name)

Date: _____