Orthodontic SPECIALISTS

Date _____ Date of Birth _____ Age _____ Height _____ SEX: M _____ F _____

Name _____ Nickname _____
(FIRST) (MIDDLE) (LAST)

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	❑	❑	_____	Diabetes	❑	❑	_____	Fainting spells	❑	❑	_____	Rheumatic fever	❑	❑	_____
Adenoids (removed)	❑	❑	_____	Ear/Nose infections	❑	❑	_____	Heart disorder/ murmur	❑	❑	_____	Scoliosis	❑	❑	_____
Allergies	❑	❑	_____	Emotional	❑	❑	_____	Hepatitis	❑	❑	_____	Speech difficulty	❑	❑	_____
Blood/Bleeding problems	❑	❑	_____	Endocrine disorder	❑	❑	_____	Hospitalized	❑	❑	_____	Tonsils (removed)	❑	❑	_____
Bone disorder	❑	❑	_____	Epilepsy	❑	❑	_____	Learning disorder	❑	❑	_____	Sexually transmitted disease	❑	❑	_____
												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 _____

_____

FORM CHILD

PLEASE COMPLETE REVERSE SIDE➤

OVER➤

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: _____