Patient Name_____________________________ Preferred Name ___________________Age___________

☐ Male ☐ Female Date of Birth _____________ School________________________ Grade ___________

Hobbies/Interests____

Home Address __________________________________City _______________________ Zip__________

Home Phone ____________________E-mail _____________________________Cell #________________

Patient's Dentist_________________________________ Date of last Visit __________________________

Who can we thank for referring you to our office? ____
☐Internet ☐Yellow Pages ☐Front Sign ☐Flyer ☐Other_____________________

Father's Name __________________________Social Security # ________________ DOB ____________

Employer____ ________________________________ Phone # __________________________________

Mother's Name _______________________Social Security # ___________________DOB____________

Employer ____________________________________Phone #__________________________________

Person Responsible for Account _____________________________Relationship___________________

Do you have orthodontic insurance? ☐ Yes No ☐

Primary Name of Insurance __________________________________Phone #______________________

Name of Policy Holder _____________________________________Group or Local #_______________

Secondary Name of Insurance ________________________________Phone #______________________

Name of Policy Holder _____________________________________Group or Local #_______________

PLEASE CHECK THE FOLLOWING AS THEY MAY APPLY

☐ Jaw Joint Problems
☐ Heart Problems
☐ Kidney Problems
☐ Liver Disease/Hepatitis
☐ Endocrine Disorder
☐ Pregnancy
☐ Aids
☐Congenital Heart Conditions

☐ High Blood Pressure
☐ Head or Facial Injury
☐ Ear Infections
☐ Allergies
☐ Nervous Disorder
☐ Asthma
☐ ADHD

☐ Diabetes
☐ Bleeding Disorder
☐ Epilepsy
☐ Speech Problems
☐ Rheumatic Fever
☐ Autism
☐ Artificial Joints
☐ If Other, Please Explain___________

____

Is the patient under a physician's care at the present time? □No □ Yes   If yes, please explain____

____

DENTAL HISTORY

Has the patient had any injuries to the face, mouth or teeth? □Yes No□ Explain
____

Has the patient ever sucked a thumb or finger? □Yes □ No (If yes, until what age ___________________

Has the patient received previous orthodontic care? □ Yes No □   By whom______________________

What part of your child's orthodontic problem concerns you the most? ___________________________

Is there any additional information that you feel would make this a more enjoyable experience for your child? ____

Signature_______________________________________Date__________________________________

TO BE SIGNED AT APPOINTMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____________________________________, have received a copy of this notice of privacy
Parent or guardians signature
Practices.

Please Print Name____

Signature __________________________________Date ______________________________________

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but could not be obtained because:

□Individual refused to sign

□Communication barriers prohibited the acknowledgment

□An Emergency situation prevented us from obtaining the acknowledgment

□Other (please specify)____