Child Patient Information & Medical/Dental History

Fleming | Wise | Scherer
SPECIALIST IN ORTHODONTICS

TODAY'S DATE_____ UPDATED_____ UPDATED _____

Please Complete in Ink

PATIENT'S INFORMATION

LAST NAME

FIRST NAME

I PREFER TO BE CALLED

AGE | SEX | DATE OF BIRTH

ADDRESS

CITY | STATE | ZIP

HOME PHONE

CELL PHONE

SCHOOL | GRADE

SPORTS/HOBBIES

PATIENT'S FAMILY DENTIST

FAMILY PHYSICIAN

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

PRIMARY RESPONSIBLE PARTY

MOTHER FATHER STEP PARENT OTHER (SPECIFY)

LAST NAME

FIRST NAME

HOME PHONE

CELL PHONE

SSN (FOR ACCOUNTING PURPOSES ONLY)

MARITAL STATUS: SINGLE MARRIED DIVORCED REMARRIED WIDOWED

ADDRESS

CITY | STATE | ZIP

E-MAIL ADDRESS

EMPLOYER

WORK PHONE

SPOUSE'S NAME

EMPLOYER

WORK PHONE

PLEASE DESCRIBE YOUR PRIMARY CONCERN WITH YOUR SMILE, ALIGNMENT OF TEETH AND/OR BITE:

INSURANCE INFORMATION

Please fill out completely so we may properly file your insurance

PRIMARY ORTHODONTIC INSURANCE

IDENTIFICATION NO.

GROUP NO.

INS. CO. PHONE

NAME OF POLICY HOLDER

POLICY HOLDER'S BIRTHDATE

RELATIONSHIP TO PATIENT

ADDRESS

PHONE

SSN

EMPLOYER

SECONDARY ORTHODONTIC INSURANCE

IDENTIFICATION NO.

GROUP NO.

INS. CO. PHONE

NAME OF POLICY HOLDER

DATE OF BIRTH

RELATIONSHIP TO PATIENT

ADDRESS

PHONE

SSN

EMPLOYER

MEDICAL HISTORY

Has patient had or does patient have any of the following?

YES	NO	
○	○	BIRTH DEFECTS/HEREDITARY PROBLEMS
○	○	CONGENITAL HEART DEFECTS
○	○	RHEUMATIC FEVER/RHEUMATIC HEART DISEASE
○	○	ARTIFICIAL (PROSTHETIC) HEART VALVE
○	○	HEART MURMUR/MITRAL VALVE PROLAPSE
○	○	BACTERIAL ENDOCARDITIS
○	○	HEART ATTACK/STROKE
○	○	HIGH OR LOW BLOOD PRESSURE
○	○	PROLONGED BLEEDING OR BLOOD DISORDER
○	○	JOINT REPLACEMENT
○	○	BONE DISORDER
○	○	ARTHRITIS
○	○	MUSCULAR DYSFUNCTION
○	○	SKIN DISORDER
○	○	TUBERCULOSIS
○	○	HEPATITIS OR OTHER LIVER DISEASE
○	○	KIDNEY DISORDER
○	○	DIABETES
○	○	ENDOCRINE OR THYROID DISORDER
○	○	SEIZURES, EPILEPSY OR NEUROLOGICAL DISORDER
○	○	EMOTIONAL OR BEHAVIORAL DISORDER
○	○	CANCER OR TUMOR
○	○	AIDS OR HIV INFECTION
○	○	COLD SORES/HERPES (ANY TYPE)
○	○	APHTHOUS ULCERS/CANKER SORES
○	○	ASTHMA
○	○	ALLERGIES, HAY FEVER OR CHRONIC SINUS INFECTION
○	○	DISEASE OF THE EYES, EARS, NOSE, OR THROAT
○	○	TONSIL OR ADENOID PROBLEMS
○	○	PERSISTENT HEADACHES/MIGRAINES

Does patient have any known allergies:

- ○ LATEX
- ○ METALS (JEWELRY)
- ○ ASPIRIN
- ○ IBUPROFEN (MOTRIN, ADVIL)
- ○ PENICILLIN OR OTHER ANTIBIOTICS
- ○ CODEINE OR OTHER NARCOTICS
- ○ LOCAL ANESTHETICS (NOVOCAINE)
- ○ OTHER (SPECIFY)

Is patient under a physician's care at present?
If yes, reason

Is patient currently taking any prescription or over-the-counter medications? If yes, please name them

Please list any other significant information about the patient's medical history

DENTAL HISTORY

MOST RECENT EXAMINATION BY FAMILY DENTIST — MONTH ____ YEAR ____

LAST DENTAL CLEANING — MONTH ____ YEAR ____

Yes	No	
○	○	Have you previously had orthodontic treatment (braces)? If yes, Dr. Name, and when?
○	○	Do any of your teeth hurt? If yes, where? ○ Upper Right ○ Upper Left ○ Lower Right ○ Lower Left
○	○	Have you had any periodontal (gum) problems? If yes, describe
○	○	Have you had wisdom teeth removed?
○	○	Have you had any injury to teeth, jaw fractures, cysts or infections? If yes, describe
○	○	Have you had any injury or hard blows to head, neck, jaw or chin? If yes, describe
○	○	Do you have a mouth breathing habit or difficulty breathing through your nose? If yes, describe
○	○	Do you clench or grind your teeth? If yes, ○ While Sleeping ○ Under Stress ○ Other
○	○	Do your jaw muscles often feel tired? If yes, when?
○	○	Do you have soreness, tightness or pain in the muscles around your jaws and face? If yes, describe
○	○	Does it hurt to chew? If yes, where does it hurt?
○	○	Do you hear clicking, popping or grating sounds in your jaw joints? If yes, ○ Right ○ Left ○ Sudden Onset ○ Gradual Onset Since when?
○	○	Was there a specific event that started the joint sounds? If yes, describe
○	○	Do you have pain in your jaw joints? If yes, ○ Right ○ Left Since when? ○ Sudden Onset ○ Gradual Onset During what activity? What increases the pain? What decreases the pain?
○	○	Has your jaw ever "locked" open?
○	○	Has your jaw ever "locked" closed?

Do you have any of the following habits?

YES NO

- Thumb or finger sucking (circle which)
  If so, until what age?
- Lip biting or entrapment of lip behind front teeth
- Nail biting If so, until what age?
- Gum chewing
- Ice chewing
- Has any other member of the family had orthodontic treatment?
  Names and ages of brothers and sisters:

Would you like to have Text Message Appointment reminders?

Yes No (standard messaging & data rates may apply)

List cell phone number(s) to receive appointment reminders:

Growth And Development / Adolescent Growth Potential

YES NO

- Has patient reached puberty yet?
  (which marks the onset of the adolescent growth spurt)
- Girls: Has monthly cycle started yet?
  If so, approximately when? Pregnant?
- Boys: Has voice changed yet?
  If so, approximately when
  Patient's height _____ ft _____ in.
  Father's height _____ ft. _____ in.
  Mother's height _____ ft. _____ in.
- Does patient have any learning disabilities or need extra help with instructions?

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to patient's medical/dental status, I recognize that it is my responsibility to inform this office.

Signature Date Signed Doctor's Signature

Medical History Update/HIPPA

SIGNATURE	DATE SIGNED	SIGNATURE	DATE SIGNED
SIGNATURE	DATE SIGNED	SIGNATURE	DATE SIGNED
SIGNATURE	DATE SIGNED	SIGNATURE	DATE SIGNED
SIGNATURE	DATE SIGNED	SIGNATURE	DATE SIGNED
SIGNATURE	DATE SIGNED	SIGNATURE	DATE SIGNED
SIGNATURE	DATE SIGNED	SIGNATURE	DATE SIGNED
SIGNATURE	DATE SIGNED	SIGNATURE	DATE SIGNED

HIPAA PRIVACY NOTICE

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, E-mail addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e. your general Dentist, Oral Surgeon, etc) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgeries etc.).
- To third party payors or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefit, dates of payment, etc.).
- To certifying, licensing and accrediting bodies (i.e. the American Board of Orthodontics, State Dental boards, etc.) in connection with obtaining certification, licensure or accreditation.
- Internally to all staff members who have any role in your treatment.
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, in which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and
- If you feel that your privacy rights have been violated by us, you may file a complaint (without risk of retaliation) to our office privacy contact person or to the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in the Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address.

PATIENT/PARENT ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed this Privacy Notice

Signature of Patient/Parent

Date

Received copy: Please Initial

Declined copy: Please Initial