

NEW PATIENT FORM (CHILD)

How did you hear about us? _____

What is the most important thing you would like for us to fix? _____

Appointment Reminder Preference: Text Phone Call Email (Email Address: _____)

Patient Name (First, Middle Initial, Last): _____	
Birth Date: _____ Age: _____	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
S.S.N.: _____	Home Phone No.: _____
Patient's Address: _____	
City: _____	State: _____ Zip/Postal Code: _____
No. of brothers and sisters: _____ Ages: _____	The AAO recommends a child have an orthodontic check-up no later than age 7. Schedule your child a free consultation today!
Other family members treated here: _____	
Father's name: _____	Cell Phone: _____
Address: _____	
Mother's Name: _____	Cell Phone: _____
Address: _____	

Dentist Name: _____	Phone: _____
Address: _____	
Physician's name: _____	Phone: _____
Address: _____	

PRIMARY INSURANCE INFORMATION
Name of Insured: _____
Date of Birth: _____
Social Security#: _____
Employer: _____
Work Phone: _____
Employer Address: _____
City _____ State _____ Zip _____
Insurance Company: _____
Group #: _____
Address: _____

SECONDARY INSURANCE INFORMATION
Name of Insured: _____
Date of Birth: _____
Social Security#: _____
Employer: _____
Work Phone: _____
Employer Address: _____
City _____ State _____ Zip _____
Insurance Company: _____
Group #: _____
Address: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: _____

PATIENT PROFILE

- Yes No Does patient follow directions well?
- Yes No Does patient brush his/her teeth at least 2 times per day?
- Yes No Does patient have learning disabilities or need extra help with instructions?
- Yes No Is patient sensitive or self-conscious about teeth?
- Yes No Is the patient pregnant?

MEDICAL HISTORY: Now or in the past, has the patient had:

- Yes No Birth defects or hereditary problems?
- Yes No Bone fractures, any major accidents?
- Yes No Rheumatoid or arthritic conditions?
- Yes No Endocrine or thyroid problems?
- Yes No Kidney problems?
- Yes No Diabetes?
- Yes No Cancer, tumor, radiation treatment or chemotherapy?
- Yes No Stomach ulcer or hyperacidity?
- Yes No Polio, mononucleosis, tuberculosis or pneumonia?
- Yes No Problems of the immune system?
- Yes No AIDS or HIV positive?
- Yes No Hepatitis, jaundice or liver problems?
- Yes No Fainting spells, seizures, epilepsy or neurological problem?
- Yes No Mental health disturbance of behavioral problem?
- Yes No Vision, hearing, tasting or speech difficulties?
- Yes No Loss of weight recently, poor appetite?
- Yes No History of eating disorder (anorexia, bulimia)?
- Yes No Bleeding disorder, bruising tendency, excessive bleeding or anemia?
- Yes No High or low blood pressure?
- Yes No Tires easily?
- Yes No Chest pain, shortness of breath or swelling ankles?
- Yes No Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- Yes No Skin disorder?
- Yes No Does the patient eat a well-balanced diet?
- Yes No Frequent headaches, colds or sore throats?
- Yes No Eye, ear, nose or throat condition?
- Yes No Hayfever, asthma, sinus trouble or hives.
- Yes No Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

- Yes No Local anesthetics (Novocaine or Lidocaine)?
- Yes No Aspirin?
- Yes No Ibuprofen (Motrin, Advil)?
- Yes No Penicillin or other antibiotics?
- Yes No Sulfa drugs?
- Yes No Codeine or narcotics?
- Yes No Metals (jewelry, clothing snaps)?
- Yes No Latex (gloves, balloons)?
- Yes No Vinyl?
- Yes No Acrylic?
- Yes No Animals?
- Yes No Foods (specify)? _____
- Yes No Other substances (specify)? _____

Yes No Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

- Yes No Does the patient currently have or ever had a substance abuse problem?
- Yes No Does the patient chew or smoke tobacco?
- Yes No Operations? (specify) _____
- Yes No Hospitalized? (for) _____
- Yes No Other physical problem or symptoms? (describe) _____
- Yes No Being treated by another health care professional? (for) _____
Date of most recent physical exam: _____
- Yes No Are there any other medical conditions that we should be aware of?

I have read and understand the above questions. I will not hold my orthodontist or any staff member responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date signed: _____
(Parent or Guardian)

Signed: _____ Date signed: _____
(Dental Staff Member)

DENTAL HISTORY: Now or in the past, has the patient had:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Would patient object to wear orthodontic appliances (braces) should they be indicated?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Concerns about his/her profile?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Concerns about spaced, crooked or protruding teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aware or concerned about under or over developed jaw?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any relative with similar tooth or jaw relationships?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have teeth grown in quickly or slowly?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Primary teeth removed by his/her Dentist?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thumb, finger or sucking habit? Until what age? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abnormal swallowing or tongue thrust habit?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of speech problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth breathing habit, snoring or difficulty in breathing?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Had periodontal (gum) treatment?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Permanent or "extra" (supernumerary) teeth removed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chipped teeth or other wise injured teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Teeth sensitive to hot or cold; throb or ache?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw fractures, cysts or mouth infections?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Dead teeth" or root canals treated?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Food impactions between teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tooth grinding, jaw clenching, clicking or locking?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain in jaw or ringing in the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain or soreness in the muscles of the face or around the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty in chewing or jaw opening?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any loose, broken or missing fillings?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Gum Boils" canker sores, or cold sores?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Taking any forms of fluoride?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any serious trouble associated with any previous dental treatment?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the patient ever had an orthodontic examination or received orthodontic treatment before?
		Doctor's name: _____ Date of Exam/Treatment: _____
		Reason for not starting treating with that Doctor? _____

I have read and understand the above questions. I will not hold my orthodontist or any staff member responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date signed: _____
(Parent or Guardian)

Signed: _____ Date signed: _____
(Dental Staff Member)

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA):

You may refuse to sign this Acknowledgement. I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature of Guardian: _____

Date: _____

Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with *The Brace Place*, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with *The Brace Place*
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with *The Brace Place* about ways to keep your communications safe and confidential.

I, _____ authorize The Brace Place at 2630 S. Carrier Pkwy,
Grand _____ (name of patient or guardian) Prairie
TX 75052

TO TRANSMIT PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY THE FOLLOWING NON-SECURE MEDIA:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Information concerning my treatment including photos and radiographs.

TERMINATION

This authorization will terminate one month after termination of my orthodontic treatment.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

Signature of patient or guardian

Date

Printed Name of Patient

Printed Name of Signer if other than the patient