NEW PATIENT FORM

Patient's name **(First and Last Name):** _____ Phone Number: _____

If minor, Parent/Guardian's Name: _____ Marital Status: _____

Patient/Parent/Guardian's Employer: _____ Years with this employer: _____

Home Address: _____ Years at this address: _____

Patient's Date of Birth: _____ Email Address:_____

Dentist Name: _____ How did you hear about our office?_____

What concerns you or your dentist the most about your teeth? _____

MEDICAL HISTORY
Now or in the past, have you had?

☐ High/Low Blood Pressure	☐ Bone Fractures	☐ Rheumatoid or Arthritic Condition	☐ Bleeding Disorder
☐ Kidney Problems	☐ Diabetes	☐ Cancer/Radiation or Chemo Therapy	☐ Stomach Ulcer
☐ Immune System Problems	☐ A.I.D.S. / H.I.V	☐ Chest Pain/Shortness of Breath	☐ Heart Problems
☐ Mental Health Disturbances	☐ Behavioral Problem	☐ Vision/Hearing/Taste/Speech Difficulty	☐ Eating Disorder
☐ Endocrine or Thyroid Disease	☐ Sleep Apnea	☐ Birth Defects/ Hereditary Problems	☐ Hepatitis/Jaundice
☐ Fainting/Epilepsy/Seizures	☐ Skin Problems	☐ Tonsil or Adenoid Condition	☐ Asthma
☐ Hip/Knee/Joint Replacement	☐ Osteoporosis	☐ Frequent Headaches Colds or Sore Throats	☐ Ear, Eyes, Nose, Throat Condition

☐ Other:_____

Females Only: Is the patient currently pregnant? ☐ Yes ☐ No

Please list any medications or supplements:

Medication: _____ Taken for: _____ Medication: _____ Taken for: _____

Medication: _____ Taken for: _____ Medication: _____ Taken for: _____

ALLERGIES

☐ Local Anesthetic	☐ Penicillin	☐ Latex	☐ Vinyl	☐ Nickel/Metals
☐ Acrylic	☐ Aspirin	☐ Others:_____		

DENTAL HISTORY

☐ Thumb sucking	☐ Mouth breathing/difficulty breathing	☐ Snoring
☐ Periodontal disease	☐ Teeth grinding,/jaw clenching	☐ Clicking or Locking of Jaw
☐ Pain in the jaw	☐ Pain or soreness in the face or around ears	☐ Difficulty opening or closing

Do you have a flex spending plan you want to use? ☐ Yes ☐ No

Have you ever had an orthodontic examination or received orthodontic treatment before? ☐ Yes ☐ No

If so, what is the name of the office/ Doctor? _____

On a scale of 1 to 5, 5 being ready to start, how ready are you to start treatment? _____

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.

_____ _____
Signature of Patient/Parent/Guardian Patient/Parent/Guardian's Printed Name

_____ _____
Date Dental Staff Member's Signature

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.

_____ _____
Signature of Patient/Parent/Guardian Patient's Name

_____ _____
Date Parent or Guardian's Printed Name

You can view our HIPAA form by scanning the code below or by going to https://braceplace.net/new-patients/patient-forms/

Patient Name: _____

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. The type of information we may send may include information related to the scheduling of meetings or other appointments, information related to billing and payment, and information concerning my treatment including photos and radiographs.

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

TO TRANSMIT PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY EMAIL, TEXT MESSAGE AND OTHER NON-SECURE MEANS AS DESCRIBED IN OUR COMMUNICATION BY EMAIL, TEXT MESSAGING AND OTHER NON-SECURE MEANS PAPERWORK YOU RECEIVED.

TERMINATION
This authorization will terminate three months 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/parent/guardian Date

Health Information Access

I give permission for Dr. Lateefah Washington and her staff to share the above-mentioned patient's protected health information with people listed below **(including myself)**:

_____ _____
Name and Relationship Name and Relationship

_____ _____
Name and Relationship Name and Relationship

_____ _____
Signature of patient/parent/guardian Date

NOTE: If you wish to add or terminate information access to or from the above list, you must submit your request in writing to our office.

Photo Release Form

I, _____, hereby grant permission to The Brace Place to use my photographs regarding the dental care I received, in any marketing, advertising or teaching materials used to market or advertise the dental practices, including use on The Brace Place web site, Facebook page, or online blog. I acknowledge The Brace Place's right to crop or otherwise treat the photograph at his/her discretion. I also acknowledge that The Brace Place may choose not to use my photograph at this time, but may do so at his/her own discretion at a later date. I also understand that once my image is posted on The Brace Place website, Facebook page, or online blog, any computer user, which is beyond control of The Brace Place, can download the image and I will hold him/her and any of his/her affiliated offices harmless from any such use or download.

I hereby freely and voluntarily consent to the use of my photograph as stated above until I revoke this consent in writing.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Printed Name of Patient

To revoke this consent in writing, please contact:
The Brace Place
2630 S. Carrier Pkwy, Suite A
Grand Prairie, TX 75052

Consent to Treat Minor without Parent Present

Patient Name: _____

I do hereby give my full permission to perform any necessary dental treatment for my child (name above) in my absence. This includes x-rays, examinations or necessary treatment.

_____ _____

Signature of Parent or Guardian Date