Family ORTHODONTICS

Welcome to our office! So that we can best meet your orthodontic needs, please complete both sides of this medical/dental questionnaire. When you have finished, please return it to one of our staff members and we will be with you shortly.

PATIENT INFORMATION:

Name: _____ Nickname: _____ Birthday: _____

Address: _____ City: _____ State: _____ ZIP: _____

What school does your child attend? _____

Patient lives with: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other:

CONTACT INFORMATION:

Phone Number: _____ ☐ Text to confirm appointments

Emergency Contact: _____ Phone: _____

Email: _____ ☐ Email to confirm appointments

MOTHER (OR GUARDIAN) INFORMATION:

Name: _____ ☐ I am financially responsible

Address (If different than above): _____

Phone: _____ Email: _____

Birthday: _____ Social Security Number (Needed for insurance): _____ - _____ - _____

FATHER (OR GUARDIAN) INFORMATION:

Name: _____ ☐ I am financially responsible

Address (If different than above): _____

Phone: _____ Email: _____

Birthday: _____ Social Security Number (Needed for insurance): _____ - _____ - _____

DENTAL INSURANCE INFORMATION:

Insurance Company Name: _____ Member/Policy Number: _____

Group Number: _____ Claims Address: _____ Provider Phone: _____

Which parent is the primary insurance subscriber? _____

OTHER INFORMATION:

How did you hear about our office? _____ Siblings at our office: _____

Dentist Name: _____ Last dental visit: _____ X-rays taken? _____

Physicians Name: _____ Specialist Name (if any): _____

PATIENT MEDICAL HISTORY

☐ Y ☐ N Are you in good health?

☐ Y ☐ N Are you under the care of a physician? If so, for what reason? _____

☐ Y ☐ N Are you taking any medications? If so, please list: _____

☐ Y ☐ N Do you have any allergies? If so, please list: _____

DOES THE PATIENT HAVE A HISTORY OF:

☐ Y ☐ N Asthma
☐ Y ☐ N Breathing Problems
☐ Y ☐ N Troubles swallowing
☐ Y ☐ N Tonsils or adenoids removed
☐ Y ☐ N Heart Problems
☐ Y ☐ N Seizures/Epilepsy
☐ Y ☐ N Prolonged Bleeding

☐ Y ☐ N Sleep apnea
☐ Y ☐ N Mouth breathing
☐ Y ☐ N Ear problems
☐ Y ☐ N Speech problems
☐ Y ☐ N Rheumatic fever
☐ Y ☐ N Diabetes
☐ Y ☐ N HIV or Hepatitis

PATIENT DENTAL HISTORY

☐ Y ☐ N Have you had a recent dental check-up? If so, when? _____

☐ Y ☐ N Have you had previous orthodontic treatment or an orthodontic consultation?

If so, when and where? _____

☐ Y ☐ N Does anyone else have a similar bite? If so, who? _____

☐ Y ☐ N Is the patient adopted?

DOES THE PATIENT HAVE A HISTORY OF:

☐ Y ☐ N Trauma to the face or teeth
☐ Y ☐ N Thumb or finger sucking habit
☐ Y ☐ N Night time teeth grinding habit
☐ Y ☐ N Loss of permanent teeth
☐ Y ☐ N Cleft lip or palate
☐ Y ☐ N Pain or tenderness in the jaw joints
☐ Y ☐ N Sounds of clicking in the jaw joints when opening or closing
☐ Y ☐ N Difficulty chewing or eating
☐ Y ☐ N Sores or ulcers in the mouth
☐ Y ☐ N Cold sores or fever blisters
☐ Y ☐ N Endodontic treatment/root canal therapy
☐ Y ☐ N Dental crowns or bridges
☐ Y ☐ N Dental implants

SIGNATURE: _____ **DATE:** _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security: _____ - _____ - _____

Email: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice Accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Family Orthodontics
Telephone 561-744-5456 Fax 561-7 44-9803
E-mail: Frontdesk@westfamilyortho.com
Address: 1851 W. Indiantown Road, Suite #201, Jupiter, Florida 33458

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: _____ **DATE:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation, I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

SIGNATURE: _____ **DATE:** _____

Family
ORTHODONTICS

SOCIAL MEDIA INFORMED CONSENT

Family Orthodontics is pleased to participate in social media outlets such as Facebook, Instagram, YouTube, Google+, etc. Through these sites, we share pictures, office updates, new contests, and other fun and helpful information that may benefit our patients and our community. With the expressed permission of our patients, or parental guardians, we are pleased to share posts welcoming new patients to our practice, congratulating patients completing their treatment, and posting photos of our patient's beautiful new smiles.

☐ I give my consent to allow Family Orthodontics to post updates or photographs of (me/my child) on social media.

☐ I do not give my consent to (my/my child's) information being shared on social media.

NAME OF PATIENT: _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

DATE: _____

Comments or Specific Directions:

_____

_____

_____

_____

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Telephone 561-744-5456 Fax 561-7 44-9803

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