PATIENT INFORMATION

NAME: _____ PREFERRED NAME: _____

BIRTHDATE: _____ AGE: _____ SSN: _____ GENDER: ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____ ZIP: _____

CELL PHONE: _____ EMAIL: _____

SCHOOL: _____ GRADE: _____

DENTIST: _____ DATE OF LAST VISIT: _____

SIBLINGS: (Name & DOB) _____

HAS THE PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? ☐ YES ☐ NO IF SO, WHERE? _____

PARENT/GUARDIAN INFORMATION

NAME: _____ EMAIL: _____

HOME ADDRESS: _____ # OF YEARS @ ADDRESS: _____

PHONE: (cell) _____ (work) _____ (home) _____

EMPLOYER: _____ # OF YEARS: _____ OCCUPATION: _____

BIRTHDATE: _____ SSN: _____

INSURANCE INFORMATION

INSURED NAME: _____ BIRTHDATE: _____ SSN: _____

INSURED ADDRESS: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

INS. ID#: _____ GROUP#: _____ INS. PHONE#: _____

CLAIMS ADDRESS: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Retention of Documents Relating to Patient Care. By signing this, you understand and agree that it is our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME _____ **SIGNATURE** _____ **DATE** _____

DENTAL HISTORY

CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:

☐ Blisters on lips/mouth
☐ Broken fillings
☐ Burning sensation, tongue
☐ Chews on tongue
☐ Dry mouth
☐ Extracted teeth
☐ Finger/thumb habits
☐ Food trapped between teeth
☐ Grinding teeth
☐ Gums bleeding
☐ Gums sore/swollen
☐ Injuries to teeth/jaw
☐ Injuries to face/head
☐ Jaw clicking/popping
☐ Jaw locking open/closed
☐ Jaw pain/tenderness
☐ Jaw surgery
☐ Lip/cheek biting
☐ Loose teeth (other than baby teeth)
☐ Mouth breathing
☐ Mouth pain when brushing
☐ Orthodontic treatment
☐ Pain around ear
☐ Periodontal treatment
☐ Periodontal surgery
☐ Sensitivity to hot or cold
☐ Sensitivity to sweets
☐ Sensitivity to pressure
☐ Sores/growths in mouth
☐ Speech problems
☐ Tongue thrust

HOW OFTEN DOES THE PATIENT BRUSH? _____ FLOSS? _____

ADDITIONAL COMMENTS: _____

MEDICAL HISTORY

CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:

☐ AIDS
☐ Anem
☐ Arthritis
☐ Artificial heart valves
☐ Artificial joints
☐ Asthma
☐ Back problems
☐ Blood diseases
☐ Bone disorders
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Cortisone treatment
☐ Coughing - persistent
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems
☐ Hepatitis
☐ High blood pressure
☐ HIV Positive
☐ Kidney disease
☐ Liver disease
☐ Mitral valve prolapse
☐ Nervous system problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation treatment
☐ Respiratory disease
☐ Scarlet fever
☐ Shortness of breath
☐ Stroke
☐ Stomach ulcers
☐ Swelling of feet
☐ Thyroid problems
☐ Tobacco habit
☐ Tonsillitis
☐ Tonsils removed
☐ Tuberculosis
☐ Urinary problems

☐ Other (not listed) _____

FEMALES ONLY IS IT POSSIBLE THE PATIENT IS PREGNANT? ☐ YES ☐ NO

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

FOR WHAT CONDITION? _____

PHYSICIAN'S NAME: _____ PHONE #: _____

MEDICATIONS:
Please list **ANY & ALL** medications the patient is currently taking:

_____

_____

_____

ALLERGIES:
Please list **ANY & ALL** known allergies you are aware of (EXAMPLE(S): Latex, Metal, Medications):

_____

IS THE PATIENT CURRENTLY TAKING OR HAS TAKEN ANY BONE DENSITY MEDICATIONS? ☐ YES ☐ NO
(Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

The above information is accurate and complete to the best of my knowledge and is only for use in my child's treatment. It is my responsibility to inform this office of any changes in my child's personal information or health status. I will not hold this office, our doctors or our staff responsible for any errors or omissions that I have made in the completion of this form.

NAME _____ **SIGNATURE** _____ **DATE** _____

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form. Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent. Thank you for your cooperation. Please let us know if you have any questions.

Signature:_____ **Date**: _____

PATIENT PHOTO RELEASE

Patient Name: _____

The above named patient (or parent/legal guardian) of San Antonio Orthodontics, consents to: (i) have the patient's likeness and/or voice recorded on a video, audio, photographic, digital, electronic or any other medium; (ii) the use of their name in connection with such recordings; and (iii) the use, reproduction, exhibition, and/or distribution of their name and such recordings in any medium (e.g. print publications, video, internet, etc.) for promotional, advertising, education, and/or other lawful purposes. The patient (or parent/guardian) releases and waives any claims or rights of ownership or compensation regarding such uses and understands that all such recordings shall remain the property of San Antonio Orthodontics.

❏ I authorize the recording and use of photo/videos as outlined above

❏ I DO NOT authorize the recording and use of photos/videos as outlined above

Signature: _____ **Date:** _____