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 1 INFORMATION - Financially Responsible Party? ☐ YES ☐ NO

NAME: ______________________ EMAIL: ______________________

HOME ADDRESS: ______________________ # OF YEARS @ ADDRESS: __________

PHONE: (cell) ______________ (work) ______________ (home) ______________

EMPLOYER: ______________ # OF YEARS: ______ OCCUPATION: ______________

BIRTHDATE: ______________ SSN: ______________

PARENT/GUARDIAN 2 INFORMATION - Financially Responsible Party? ☐ YES ☐ NO

NAME: ______________________ EMAIL: ______________________

HOME ADDRESS: ______________________ # OF YEARS @ ADDRESS: __________

PHONE: (cell) ______________ (work) ______________ (home) ______________

EMPLOYER: ______________ # OF YEARS: ______ OCCUPATION: ______________

BIRTHDATE: ______________ SSN: ______________

INSURANCE INFORMATION

INSURED NAME: ______________ BIRTHDATE: __________ SSN: ______________

RELATIONSHIP TO PATIENT: __________ INSURED ADDRESS: ______________________

EMPLOYER: ______________________ INSURANCE COMPANY: ______________

INS. ID#: ______________ GROUP#: ______________ INS. PHONE#: ______________

CLAIMS ADDRESS: ______________________________________

SECONDARY INSURANCE INFORMATION (if applicable)

INSURED NAME: ______________________ BIRTHDATE: ____________ SSN: ______________

RELATIONSHIP TO PATIENT: __________ 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** ______________

PATIENT NAME:______________________________

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** ______________________

HIPAA FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPM"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certification.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

May we phone/text/email you regarding your appointment?	**YES**	**NO**
May we send e statements in regards to your account?	**YES**	**NO**
May we leave a message on your answering machine or voicemail?	**YES**	**NO**
May we discuss your medical condition with any member of your family?	**YES**	**NO**

If **YES**, please name the members allowed:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HIPAA Privacy

I, ______________________________ (print name) have received a copy of this office's Notice of Privacy Practices.

______________________________ ______________________________

Signature Date

NOTICE OF FILMING AND PHOTOGRAPHY

Patient Name: ______________________________

When you enter San Antonio Orthodontics (SAO) you are entering an area where photography, audio, and video recording may occur.

By entering the premises, you consent to interview(s), photography, audio recording, video recording and its/their release, publication, exhibition, or reproduction to be used for news, webcasts, promotional purposes, telecasts, advertising, inclusion on websites, social media, or any other purpose by SAO and its affiliates and representatives. Images, photos and/or videos may be used to promote similar SAO events in the future, highlight the event and exhibit the capabilities of SAO. You release SAO, its officers and employees, and each and all persons involved from any liability connected with the taking, recording, digitizing, or publication and use of interviews, photographs, computer images, video and/or sound recordings.

By entering the San Antonio Orthodontics (SAO) premises, you waive all rights you may have to any claims for payment or royalties in connection with any use, exhibition, streaming, webcasting, televising, or other publication of these materials, regardless of the purpose or sponsoring of such use, exhibiting, broadcasting, webcasting, or other publication irrespective of whether a fee for admission or sponsorship is charged.

You also waive any right to inspect or approve any photo, video, or audio recording taken by SAO or the person or entity designated to do so by SAO. You have been fully informed of your consent, waiver of liability, and release before entering the premises.

Signature: ______________________________ Date: ____________________
(parent or guardian if minor)

Signature: ______________________________ Date: ____________________