



Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Age \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_ Cell # \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Date of last Visit \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Internet  Yellow Pages  Front Sign  Flyer  Other \_\_\_\_\_

Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_ Relationship \_\_\_\_\_

Do you have orthodontic insurance?  Yes  No

Primary Name of Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Group or Local # \_\_\_\_\_

Secondary Name of Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Group or Local # \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING AS THEY MAY APPLY**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Jaw Joint Problems      | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Diabetes                       |
| <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Head or Facial Injury | <input type="checkbox"/> Bleeding Disorder              |
| <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Ear Infections        | <input type="checkbox"/> Epilepsy                       |
| <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Speech Problems                |
| <input type="checkbox"/> Endocrine Disorder      | <input type="checkbox"/> Nervous Disorder      | <input type="checkbox"/> Rheumatic Fever                |
| <input type="checkbox"/> Pregnancy               | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Autism                         |
| <input type="checkbox"/> Aids                    | <input type="checkbox"/> ADHD                  | <input type="checkbox"/> If Other, Please Explain _____ |

\_\_\_\_\_

Is the patient under a physician's care at the present time?  No  Yes If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

**DENTAL HISTORY**

Has the patient had any injuries to the face, mouth or teeth?  Yes  No  Explain \_\_\_\_\_

Has the patient ever sucked a thumb or finger?  Yes  No (If yes, until what age \_\_\_\_\_)

Has the patient received previous orthodontic care?  Yes  No  By whom \_\_\_\_\_

What part of your child's orthodontic problem concerns you the most? \_\_\_\_\_

Is there any additional information that you feel would make this a more enjoyable experience for your child? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE SIGNED AT APPOINTMENT**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I \_\_\_\_\_, have received a copy of this notice of privacy Practices.  
Parent or guardians signature

Please Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For office use only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited the acknowledgment
- An Emergency situation prevented us from obtaining the acknowledgment
- Other (please specify) \_\_\_\_\_