

AMERICAN FAMILY ORTHODONTICS

1.) ABOUT YOUR CHILD	4.) FATHER'S INFORMATION
Today's Date: _____ Date of Birth: _____ Patient's Name: _____ Age: _____ Street Address: _____ City, State, Zip: _____ School Attending: _____ Grade: _____ Interest/Activities in School: _____ Patient's Dentist: _____ When was patient's last general dental cleaning? _____	Father's Full Name: _____ Street Address: _____ City, State, Zip: _____ Social Security Number: _____ Home Telephone: _____ Work Telephone: _____ Ext.: _____ Employer: _____
2.) WHO IS WITH THE CHILD TODAY?	5.) RESPONSIBLE PARTY INFORMATION
Name: _____ Relationship: _____ How did you hear about our office? _____ Do you have any family members in treatment here? _____ _____ What do you hope braces will accomplish? (chief complaint) _____ Who will be responsible for making appointments? _____ Have you seen another orthodontist recently? _____ Parent's marital status: _____ Do you have legal custody of the patient? _____ Name and ages of other children in family: _____ _____	Responsible Party's Name: _____ Street Address: _____ City, State, Zip: _____ Social Security Number: _____ Home Telephone: _____ Work Telephone: _____ Ext.: _____ Employer: _____
3.) MOTHER'S INFORMATION	6.) PRIMARY DENTAL INSURANCE
Mother's Full Name: _____ Street Address: _____ City, State, Zip: _____ Social Security Number: _____ Home Telephone: _____ Work Telephone: _____ Ext.: _____ Employer: _____	Do you have Orthodontic Insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Orthodontic Insurance: _____ _____ Mailing Address: _____ City, State, Zip: _____ Policy Holder: _____ ID: _____ DOB _____ Employer: _____ I authorize release of any information to the insurance company. _____ <div style="text-align: right;">Signature</div> I authorize payment directly to American Family Orthodontics by my insurance company _____ <div style="text-align: right;">Signature</div>

7). HEALTH HISTORY

Do you see your dentist every six months for cleaning?
 Yes No

How many times a day do you brush? _____

How is your health? Excellent Good Fair Poor

Are you under the care of a physician? Yes No

If yes, for what reason? _____

If you are taking medications, please list: _____

Name of Personal Physician: _____

If you are a female, are you pregnant? Yes No

Do you have any drug allergies or sensitivities? Yes No

If yes, what are they? _____

Have there been any injuries to face, mouth or teeth?
 Yes No

If yes, what? _____

Have you been advised to be pre-medicated? Yes No

If yes, please explain: _____

Have you ever been tested or treated for hepatitis? Yes No

Does the patient play a musical (wind) instrument? Yes No

8). PLEASE ANSWER APPROPRIATELY

Seizures Yes No

Diabetes Yes No

Heart Murmur Yes No

Mitral Valve Prolapse Yes No

Rheumatic Fever Yes No

Scarlet Fever Yes No

Tuberculosis Yes No

Asthma Yes No

Heart Trouble Yes No

Prolonged Bleeding Yes No

Mental Disorder Yes No

Attention Deficit Disorder Yes No

Scoliosis Yes No

Fainting or Dizziness Yes No

Cancer Yes No

Endocrine Problems Yes No

Blood Disorders Yes No

Immunosuppressive Disease (HIV) Yes No

Speech Problems Yes No

Seasonal Allergies Yes No

Have tonsils/adenoids been removed? Yes No

Do you get frequent headaches? Yes No

Does your jaw ever "pop"? Yes No

Has your jaw ever "locked"? Yes No

Is there any other information that may be helpful? _____

I authorize the above information to be correct. I understand it is my responsibility to notify American Family Orthodontics of any changes in my child's health history.

Signature

Date

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 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 our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving this office written notice of your revocation. 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 health care operations.

Signature

Date