PENDLETON orthodontics

New Child Patient Information

Patient Name:
_____
Last First Middle Likes to be called

Date of Birth: _____ Age: _____ Sex: _____ Email: _____

Phone: _____ School: _____ Grade: _____

Home Address: _____
Street City State Zip

Patient's Dentist: _____ Referred to us by: _____

Name and Age of other children in the family: _____

Father's Name: _____ Employment: _____ Work Phone: _____

Mother's Name: _____ Employment: _____ Work Phone: _____

Parent's Marital Status: Married Separated Divorced Remarried Widowed

List Interests/ Sports/ Hobbies of Patient: _____
Favorite TV/Movie: _____ Favorite Music: _____

Responsible Party Information

Accompanied By: _____
Last First Middle

Relationship to Patient: _____ Birthdate: _____ Social Sec.#: _____

Address (if different than patient): _____
Street City State Zip

Phone: _____ Cell/ Alternate Phone: _____

Does the patient have dental insurance coverage? Yes No

Dental Insurance Company: _____ Contact #: _____

Insurance Claims Address: _____
Street City State Zip

Subscriber Name: _____ Date of Birth: _____

Subscriber SSN: _____ Subscriber ID #: _____ Group #: _____

Medical History

For the following questions mark yes, no or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile:

Yes No DK/U

- Does patient follow directions well?
- Does the patient brush their teeth conscientiously?
- Does the patient have learning disabilities or need extra help with instruction? Is the patient self conscience or sensitive about their teeth?
- Does the patient have any sensory issues?

Medical History: Now or in the past, has the patient had any of the following:

Yes No DK/U

- Birth defects or heredity problems
- Bone fractures, any major accident
- Rheumatoid or arthritic conditions
- Endocrine or thyroid problems
- Kidney problems
- Diabetes
- Cancer, tumor radiation or chemotherapy

Stomach ulcer or hyperacidity
AIDS or HIV positive
Hepatitis, jaundice or liver problems
Fainting spells,seizures, epilepsy or neurological problems
Mental health disturbance or depression
Vision, hearing, taste or speech difficulties

Yes No DK/U
Loss of weight recently, or poor appetite
History of eating disorder
Excessive bruising, anemia or bleeding disorder
High or low blood pressure
Cardiovascular problems
Skin disorder
Frequent headaches, colds or sore throat
Ear, nose or throat condition
Hayfever, asthma, sinus trouble or hives
Tonsil or adenoid conditions

Allergies or reactions to any of the following:

Yes No DK/U
Local anesthetics (Novocaine or Lidocaine)
Aspirin
Ibuprofen (Motrin, Advil)
Penicillin or other antibiotics
Sulfa drugs
Codeine or other narcotics
Metals (jewelry, clothing snaps)
Latex (gloves, balloons)
Vinyl
Acrylic
Animals
Foods (specify) _____
Other substances (specify) _____
Is the patient taking medication, nutrient supplements, Herbal medications or non-prescription medicine?
Please name them:
Medication _____ Taken for:_____ Medication_____ Taken for:_____
Does the patient currently have or ever had a substance abuse problem? Does the patient chew or smoke tobacco?
Operations? Describe: _____ Hospitalized for?: _____
Other physical problems or symptoms? Describe:_____
Being treated by another health care professional? For: _____
Date of most recent physical exam? _____
Are there any other medical conditions that we should be made aware of?_____
Girls only:

Has the patient started her monthly periods? If so,approximately when? _____

Is the patient pregnant? _____

Family Medical History:

Do the patient's parents or siblings have any of the following health problems? If so, please explain: Bleeding disorders Unusual dental problems Diabetes Arthritis Jaw size imbalance Severe allergies

_____

Any other family medical conditions that we should know about?_____

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Dental History

Now or in the past, has the patient had:

Yes No DK/U

- Started teething very early or late
- Primary (baby) teeth removed that were not loose
- Permanent or "extra" (supernumerary) teeth removed
- Supernumerary (extra) or congenitally missing teeth
- Chipped or otherwise injured primary (baby) or permanent teeth
- Teeth sensitive to hot or cold; teeth throb or ache
- Jaw fractures, cysts or mouth infections
- "Dead teeth" or root canals treated
- Bleeding gums, bad taste or odor in the mouth
- Periodontal "gum problems"
- Food impaction between teeth
- Thumb, finger or sucking habit Until what age? _____
- Abnormal swallowing habit (tongue thrusting)
- History of speech problems
- Mouth breathing habit, snoring or difficulty in breathing
- Tooth grinding or jaw clenching
- Any pain in jaw or ringing in the ears
- Any pain or soreness in the muscles of the face or around the ears
- Difficulty in chewing or jaw opening
- Aware of loose, broken or missing restoration (fillings)
- Any teeth irritating cheek, lip, tongue or palate
- Concerned about spaced, crooked or protruding teeth
- Aware or concerned about under or over developed jaw
- "Gum boils", frequent canker sores or cold sores
- Taking any forms of fluoride
- Had periodontal (gum) treatment
- Would the patient object to wearing orthodontic appliances (braces) should they be indicated? Any serious trouble associated with any previous dental treatment
- Ever had a prior orthodontic examination or treatment
- Been under another dentist's care? Specialist: _____ Other: _____ How often does your child brush: _____ Floss: _____

What is your primary concern: _____

Why is your child here? _____

How did you hear about us? _____

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I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so infor this practice.

Signed: _____ Date signed: _____
Parent or Guardian

Signed: _____ Date signed: _____
Dental staff member

Notice of Privacy Practices

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 the 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 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.

Patient's signature: _____ Date: _____

Print Name: _____

Responsible Party (if not patient): _____ Date: _____

Print Name: _____ Relationship to patient: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

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

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement An emergency situation prevented us from obtaining acknowledgement Other (please specify):

_____