Welcome

Irmo SMILES
Family & Cosmetic Dentistry
Pediatric Dentistry
Orthodontics

Thank you for selecting our office for your orthodontic evaluation. Please help us by completing this orthodontic health questionnaire. If you have any questions or need assistance, please ask us ~ We will be happy to help you.

Patient Information *(CONFIDENTIAL)*

Date _____

Patient's Name _____
Last First Middle Initial Nickname

Age _____ Date of Birth _____ Sex _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ E-mail _____

School _____ Grade _____

Father's Name _____ Employer _____ Work Phone _____

Mother's Name _____ Employer _____ Work Phone _____

Marital Status of parents: ❒ Married ❒ Separated ❒ Divorced ❒ Single

Whom may we thank for recommending our office to you?

❒ Self ❒ Dentist ❒ Others _____

Responsible Party

Person responsible for financial matters:

Name _____ Home Phone _____ Cell _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

E-mail _____ Social Security # _____

Insurance Information

If you have orthodontic insurance, please complete the following (the person's information the insurance is under):

Name of the Insured _____ S.S. # _____ Date of Birth _____

Name of Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone No. _____

Concerns

Describe the reason for the consultation _____

Is the patient aware of the orthodontic problem? ❒ Yes ❒ No

Has the patient had previous orthodontic consultation or treatment? ❒ Yes ❒ No

Which of the following best describes the patient's interest in orthodontic treatment?

❒ Patient wants treatment ❒ Willing if treatment is necessary ❒ Unwilling, but agrees

Dental History

Dentist_____ Date of last dental examination _____

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

Has the patient ever sucked a thumb or fingers? ❒ Yes Until what age? _____ ❒ No

Is the patient a mouth breather? ❒ Yes, while a awake ❒ Yes, while asleep ❒ No

Does the patient grind his/her teeth? ❒ Yes, while a awake ❒ Yes, while asleep ❒ No

Does the patient have a speech problem? ❒ Yes ❒ No

Does the patient play a musical instrument? ❒ Yes _____ ❒ No

How often does the patient brush his/her teeth? ❒ Several times a day ❒ Once a day ❒ Occasionally ❒ Never

Have you been informed of any missing or extra permanent teeth? ❒ Yes ❒ No

Has any member of the family had orthodontic treatment? ❒ Yes _____ ❒ No

Medical History

Physician _____

Does the patient have any history of major illness? ❒ Yes _____ ❒ No

Has the patient ever been under the care of a physician for illness? ❒ Yes ❒ No

If yes, please explain _____

Place a check beside the medical conditions which the patient has now or had previously:

❒ Anemia	❒ Cancer	❒ Glaucoma	❒ Kidney disease	❒ Thyroid
❒ Arthritis	❒ Cerebral Palsy	❒ Hearing Problems	❒ Lung disorders	❒ Tuberculosis
❒ Asthma	❒ Cold sores/oral ulcers	❒ Heart disorders	❒ Nervous disorders	❒ Other
❒ AIDS/HIV	❒ Diabetes	❒ Heart murmur	❒ Pneumonia	
❒ Bleeding disorders	❒ Endocrine disorders	❒ Hepatitis	❒ Rheumatic Fever	
❒ Bone disorders	❒ Epilepsy	❒ High blood pressure	❒ Sleep Apnea	

Please comment on any checked above: _____

Does the patient have a tendency to: ❒ Colds ❒ Sore throats ❒ Ear Infections

Have the patient's tonsils and/or adenoids been removed? ❒ Yes ~ age _____ ❒ No

Does the patient have any allergies or drug sensitivities? ❒ Yes _____ ❒ No

Does the patient have a nickel allergy? ❒ Yes ❒ No

Please list all medications you are presently taking: _____

Have you ever been told you needed antibiotics before having dental work performed? ❒ Yes ❒ No

Growth & Development

Patient's height _____ Patient's weight _____

Has the patient reached puberty?

Girls ~ Has she started menstruation? ❒ Yes ❒ No

Boys ~ Has his voice changed or is facial hair growth present? ❒ Yes ❒ No

Check one of the following which best describes his/her progress in school:

❒ Behind children of the same age

❒ Same level as children of the same age

❒ Advanced beyond children of the same age

What is the patient's best subject in school? _____

Hobbies/interests/sports _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and /or health practitioners. I agree to be responsible for payment of all services. I understand that when necessary credit information may be obtained.

*X*_____

Signature of Parent or Guardian

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PATIENT HIPAA CONSENT FORM

(Acknowledgement of receipt of Notice of Privacy Practices and Consent for Use and Disclosure of Health Information)

I understand that, as part of my healthcare, this office originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and clinical information to my bill
- A means by which a third-party payer can verify that services were performed

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that this office reserves the right to change their notice and practices and will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.

Signed this _____ day of _____, 20_____

Patient name (please print): _____

Signature: _____

Relationship to Patient: _____