CHILD PATIENT INFORMATION

Tell us about your child

Child's Name: _____ DOB:_____ Age: _____

Preferred Name: _____ ☐ Male ☐ Female

School:_____ Grade: _____

Home #:_____ Cell#:_____

Email: _____

Hobbies/ Special Interests: _____

Child's Home Address: _____

_____

CITY State ZIP

Who is with your child today?

Name: _____

Relationship: _____

Do you have legal custody of this child: ☐ Yes ☐ No

Whom may we thank for referring you? _____

General Dentist: _____

General Dentist #: _____

Date of last visit: _____

Parent's Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Mother's Information

Name: _____

Work #: _____ Home # _____

Employer: _____

SS#: _____

Father's Information

Name: _____

Work #: _____ Home#_____

Employer: _____

SS#: _____

Account Holder Information

Name: _____

Billing Address: _____

_____

City State Zip

Work #: _____ Home #_____

Cell #: _____

Email: _____

Employer: _____

Primary Dental Insurance

Ins Name: _____

Ins Address: _____

_____

Ins Co #: _____

Group/Policy #_____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____

Secondary Dental Insurance

Ins Name: _____

Ins Address: _____

_____

Ins Co #: _____

Group/Policy #_____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____

CHILD PATIENT INFORMATION

What are the main concerns you would like orthodontics to accomplish?

_____

Has your child ever been evaluated or had orthodontic treatment before
☐ Yes ☐ No- if yes, Who?_____

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

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain/tenderness in the jaw?

☐ Yes ☐ No

Does your child brush his/her teeth twice daily?

☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Please list any musical instruments your child plays:

_____

Does the child exhibit any of the following behaviors?

YES	NO	
☐	☐	Nail Biting
☐	☐	Thumb Sucking
☐	☐	Teeth Grinding (Bruxism)
☐	☐	Open Mouth Breathing
☐	☐	Speech Impairment
☐	☐	Tongue Thrust (reverse swallow)

Medical History Updates:

Initial: _____ Date: _____

Initial: _____ Date: _____

Our office is committed to meeting and exceeding standards of infection control as mandated by OSHA, the CDC, and the ADA.

Health History

YES	NO		YES	NO	
☐	☐	Heart Disease	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Anemia
☐	☐	HIV+/AIDS	☐	☐	Endocrine/Thyroid
☐	☐	Hemophilia	☐	☐	Hospital Stays
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis	☐	☐	Allergies to Any Drug
☐	☐	Arthritis	☐	☐	Sleep Apnea

Please discuss any serious medical problems that the child has had:

_____

Does your child normally medicate before each dental visit? ☐ Yes ☐ No

Does your child take any bisphosphonate medications for bone disorders, such as Fosamax? ☐ Yes ☐ No

Please list and provide reasoning for any medications that are currently being taken:

_____

Please list any allergies or drug sensitivity:

_____

It is my understanding that the information I have given today is correct to the best of my knowledge. I am also aware that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I hereby authorize the staff at Buckhead Orthodontics to perform any necessary orthodontic services with my informed consent that I may need during diagnosis and treatment.

Signature: _____Date: _____

Transfer Patients Only:

I hereby authorize the transfer of my orthodontic records to Michael B. Everson, DDS, MS.

Signature: _____

Date: _____

buckhead orthodontics
Michael Everson, DDS, MS

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtaining payment from third party payers (e.g. insurance company)
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____