Serenity ORTHODONTICS

PERSONAL

Today's Date: _____/_____/_____

Patient: (Last) _____, (First) _____(MI)_____ Primary Phone (_____)_____

Birthdate: _____/_____/_____ Age: _____ Gender: [ ] M [ ] F Ethnicity: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip _____

Mother(s) Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip _____

Primary phone: (_____)_____-_____ Secondary phone: (_____)_____-_____

Father(s) Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip _____

Primary phone: (_____)_____-_____ Secondary phone: (_____)_____-_____

Patient lives with: Mom _____ Dad _____ Both _____ Emergency contact: (_____)_____-_____

School: _____ Grade: _____ Hobbies/Clubs: _____

Names & Ages of other children in the family: _____

How many ways have you heard about our office? (Check as many that apply and Circle the one that helped make your decision)

Google: _____ Social Media: _____ Mailer: _____ Ins Company: _____ Community Event: _____

School Event: _____ Personal Referral: _____ Doctor Referral: _____ Drive by: _____ Other: _____

INSURANCE

Patient relationship to Insurance Subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name: _____ Insurance Company: _____

Birthdate: _____ Subscriber ID# or SS#: _____ Group # _____

Employer: _____ Phone number: (_____)_____-_____

Person(s) responsible for the account: _____

(Please present insurance card to the front desk)

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DENTAL HISTORY

Patient's Name: _____ Birthdate: _____
Last First
Dentist/Group: _____ Phone number: (_____)_____-_____

What is the reason for your visit today?

Routine check up _____ Discomfort _____ Emergency _____ 1st visit _____

Orthodontics _____ Second opinion _____ Habit _____ Other _____

- Has patient ever seen a Dentist before: [ ] Yes [ ] No
  If yes, by whom and approximately when? _____
- Were x-rays taken? [ ] Yes [ ] No
  If yes, approximately when? _____
- Has patient had a traumatic medical or dental experience? [ ] Yes [ ] No
  If yes, please explain: _____
- Has patient ever injured any teeth or his/her mouth? [ ] Yes [ ] No
  If yes, please explain: _____
- Has patient ever experienced facial pain or had problems with the jaw joints near each ear? [ ] Yes [ ] No
- Are you on well water? [ ] Yes [ ] No
- Does patient drink NON-fluorinated water? [ ] Yes [ ] No
- Does patient take fluoride tablets, drops, or vitamins with fluoride? [ ] Yes [ ] No
- Does patient suck his/her thumb, finger, pacifier, blanket, etc..? [ ] Yes [ ] No
- Does patient grind his/her teeth? [ ] Yes [ ] No
- Does patient have difficulty breathing through the nose with his/her mouth closed? [ ] Yes [ ] No
- Is there anything else you would like us to know or that we need to know about patient's health? [ ] Yes [ ] No
  If yes, please explain: _____

The above Dental history is complete and accurate to the best of my knowledge. I will notify you of ANY change(s) in the above prior to ANY appointment(s).

_____ _____
Signed (Parent/Guardian) Date

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MEDICAL HISTORY

Patient's Name: _____ Birthdate: _____
Last First
Primary Doctor/Group: _____ Phone number: (_____)_____-_____

YES [ ] NO [ ] Is patient under the care of a physician for anything other than routine care?
If yes, please explain: _____

YES [ ] NO [ ] Does patient have a heart murmur, artificial heart valve, prosthetic joint, or any other foreign materials/objects?
If yes, please circle which one. Who is the treating/diagnosing physician? _____

YES [ ] NO [ ] Does patient have any drug allergies or ever had a reaction to a DRUG or MEDICATION?
If yes, please list the drug and the reaction: _____

YES [ ] NO [ ] Does/Did patient have allergies or a reaction to LATEX, FOODS, DYES, METALS, OR ANYTHING ELSE?
If yes, please circle which one and indicate If it's airborne, or ingested, and explain: _____

YES [ ] NO [ ] Does patient take any medications on a regular basis?
If yes, please list: _____

YES [ ] NO [ ] Does patient have any history of taking medications in the bisphosphonate drug class (Alendronate, Fosamax, etc)?
If yes, please list: _____

YES [ ] NO [ ] Is patient currently taking any medications that he/she does not normally take on a regular basis?
If yes, please list: _____

YES [ ] NO [ ] Has patient EVER been a patient in a hospital or emergency room for ANY reason?
If yes, please list and explain: _____

YES [ ] NO [ ] Does patient or anyone in your family have a condition called Methylenetetrahydroflate Reductase Deficiency (MTHFR) or Hyperhomocysteinemia?

Please check any condition patient currently has or has ever had. If NONE apply, please check NONE.

[ ] Asthma	[ ] Bone disorder	[ ] Feeding/Eating problem	[ ] Reflux
[ ] Allergy	[ ] Skin disorder	[ ] Neuromuscular problem	[ ] Fainting
[ ] Breathing/Lung problems	[ ] Premature birth	[ ] Congenital Birth Defect	[ ] POTS
[ ] Diabetes	[ ] Low birth weight	[ ] Seizure/Epilepsy	[ ] Headaches
[ ] Endocrine problems	[ ] Failure to thrive	[ ] Cancer/Tumors	[ ] Facial/Jaw Pain
[ ] Adrenal/Kidney problems	[ ] Developmental/Mental delay	[ ] Leukemia	[ ] Pregnancy
[ ] Intestinal/Stomach problems	[ ] Physical challenge	[ ] Hepatitis (A, B, C)	[ ] Head/Mouth/Teeth Injury
[ ] Liver problems	[ ] Cerebral Palsy	[ ] HIV/AIDS	[ ] Radiation/Chemotherapy
[ ] Heart disease/Murmur	[ ] Brain disorder	[ ] Tuberculosis	[ ] ADD/ADHD
[ ] High/Low Blood pressure	[ ] Eye/Ear disorder	[ ] Anemia	[ ] Hyperactivity
[ ] Rheumatic Fever	[ ] Nose/Throat disorder	[ ] Sickle Cell Trait/Disease	[ ] Anxiety/Nervousness
[ ] Arthritis	[ ] Cleft lip/palate	[ ] Blood Transfusion	[ ] Autism/Asperger's
[ ] Tonsils/Adenoids removed	[ ] Speech problem	[ ] Blood Disease	[ ] Behavior/Psychiatric issues
[ ] Tubes in Ears	[ ] Sleep Apnea/Snoring	[ ] Excessive Bleeding	[ ] NONE

If any of the above were checked, please explain: _____

YES [ ] NO [ ] Is there anything else you would like us to know or that we need to know about patient's health?
If yes, please explain: _____

The above medical and medication history is complete and accurate to the best of my knowledge. I will notify you of ANY change(s) in the above prior to ANY appointment.

_____ _____
Signed (Patient/Guardian) Date

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HIPAA Privacy Statement and Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given me under the Health 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:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice

I have also been informed 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 care information is used and disclosed to carry out treatment, payment, and health care 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.

We can only disclose your protected healthcare information under the terms of the HIPAA policies. If you wish to grant any person **other than the patient or responsible party** listed on our patient information forms to have access to your protected health information, please indicate below.

Name	Relationship to Patient	Address

Check all that you wish the person(s) above to have access to:

- ❑ Dental Treatment Records
- ❑ Medical Records
- ❑ Appointment Records
- ❑ Insurance Records
- ❑ Referral Records
- ❑ Billing Statements
- ❑ Contact Records

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HIPAA Privacy Statement and Patient Consent

Contact Information: (Patient or Responsible Party)

Name	E-mail Address	Phone Number	Preferred Method of Contact

Do we have permission to leave a voicemail message on the phone numbers listed above? __Yes __No

Expiration:

This authorization has no expiration unless I provide a written termination request as well as sign and date a new authorization form.

Patient Name (print):_____ Date:_____

Name of Parent or Guardian (if applicable): _____

Relationship to Patient:_____ Signature: _____

All patients over the age of 18 **MUST** sign their own forms. Patients under the age of 18 **CAN NOT** sign for themselves. **ONLY** a parent or legal guardian may sign for a patient under the age of 18. (Legal guardian = you are the biological parent of the minor or you have been granted custody/guardianship over this minor by the courts.)