American Family Orthodontics

Today's Date: _____

Patient Information

Patient's Name: _____

Street Address: _____

City, ST, Zip: _____

Date of Birth: _____ Age: Sex:

Cell Phone: _____

Home Phone: _____

Other Phone: _____

School: _____

Interests/Activities: _____

Dentist: _____ Phone: _____

Physician: _____ Phone: _____

Last Dental Cleaning: _____

Responsible Party

Who is with the child today (if applicable)?

Name: _____ Relationship: _____

Do you have any other family members in treatment here?

Name and Ages of other children: _____

What do you hope to accomplish with braces? _____

Have you seen another orthodontist? _____

Parent's marital status? _____

Person responsible for financial account:

Social Security #: _____

Date of Birth: _____

Mother's Information

Mother's Name: _____

Street Address: _____

City, ST, Zip: _____

Cell Phone: _____

Home Ph. # _____ WK#: _____

Date of Birth: _____

Email Address: _____

** We do not give your email address to anyone outside AFO*

Employer: _____

Social Security #:

Father's Information

Father's Name: _____

Street Address: _____

City, ST, Zip: _____

Cell Phone: _____

Home Ph. # _____ WK#: _____

Date of Birth: _____

Email Address: _____

** We do not give your email address to anyone outside AFO*

Employer: _____

Social Security #:

Orthodontic Insurance Coverage

Do you have Orthodontic Insurance coverage? Yes ☐ No ☐

If yes, name of Name of Orthodontic Insurance Carrier _____

Mailing Address: _____

Ins. Ph.#: _____ Group # _____ Member ID# _____

Subscriber Name: _____ Date of Birth: _____

Social Security #: _____

Employer: _____

I authorize release of any information to the insurance company. _____

Signature

I authorize payment directly to American Family Orthodontics by my insurance company.

_____

Signature

Health History

How often does patient see their dentist? _____

How many times a day do you brush? _____

Is the patient in good health? _____

Is the patient under the care of a physician? _____

If so, for what? _____

Please list medications the patient is currently taking:

Allergies or drug sensitivities? _____

Latex Allergies? Yes ☐ No ☐

Have tonsils and adenoids been removed? _____

Has patient received a blood transfusion since 1980? _____

Has the patient been advised to be premedicated? _____

Have there been any injuries to the face, mouth or teeth?

If so, explain: _____

Are there any problems with the jaw?

clicking ☐ Pain ☐ Opening ☐ Chewing ☐

Has patient sucked thumb or fingers? Yes ☐ No ☐

Until what age? _____

Any speech problems? _____

Mouth breather? _____

Has patient ever been informed of any missing or extra teeth?

Has any member of the family received orthodontic treatment?

Please check appropriately:

Has patient ever had any of the following?

Diabetes	☐
Pneumonia	☐
Seizures	☐
Heart Murmur	☐
Mitral Valve Prolapse	☐
Hepatitis	☐
Asthma	☐
Fainting or Dizziness	☐
Cancer	☐
Endocrine Problems	☐
Blood Disorders	☐
Immunosuppressive Disease (HIV)	☐
Frequent Headaches	☐
Jaw popping or locking	☐
Rheumatic Fever	☐
Bone Disorder	☐
Anemia	☐
Epilepsy	☐
Nervous Disorder	☐
Skin Disorder	☐

Other: _____

I authorize the above information to be correct. I understand it is my responsibility to notify American Family Orthodontics of any changes in the health history or personal information of the patient in treatment.

_____ 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 decide 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 other important matters about your protected health information. A copy of our notice is available with this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we changes our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of the protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, 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 continue treating you if you revoke this consent.

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 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