DENNEHY ORTHODONTICS

Tell Us About The Patient

Today's Date: ________________ ☐ M ☐ F

Patient's Name: ____________________________

Nickname: ________________ Birthdate: ______

Address: __________________________________

____

Home #: ___________________________________

S.S. #: ____________________________________

E-Mail: ____________________________________

Additional Info

Patients Primary Care Doctor ________________

Patient's Dentist: ___________________________

How did you hear of our office? ______________

____

School: ____________________ Grade: _______

Patient's/ Parent's chief orthodontic concerns:

____

____

____

____

Last Dental Visit:___________________________

Patient or Parents' Information

Parents' Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single

☐ Mother ☐ Step Mother ☐ Guardian Name: _________________________ DOB: __________

Address: ____ # of Years at Address: _____

Home #: ________________________ Work #: ______________________ S.S. #: ____________

Employer: ______________________ Occupation: _________________ No. Years Employed: ___

☐ Father ☐ Step Father ☐ Guardian Name: _________________________ DOB: __________

Address: ____ # of Years at Address: _____

Home #: ________________________ Work #: ______________________ S.S. #: ____________

Employer: ______________________ Occupation: _________________ No. Years Employed: ___

Person Responsible For Account

Name: ______________________________ Relation: _____________ S.S. #: ______________

Billing Address: ____ # of Years at Address: ___

Home #: ___________________ Work #: ___________________ Other #: _________________

Insurance Information

Primary

Insurance Co: _______________________ Phone #: ______________ Group #: ______________

Insurance Address: ____

Insured's Name: ____________________________________ Relation to Patient: _____________

Insured's DOB: _____________ Insurance ID #: _____________ Insured's Employer: ___________

Secondary

Insurance Co: _______________________ Phone #: ______________ Group #: ______________

Insurance Address: ____

Insured's Name: ____________________________________ Relation to Patient: _____________

Insured's DOB: _____________ Insurance ID #: _____________ Insured's Employer: ___________

Medical History

Has anyone in the family had orthodontic treatment? Y N ________________________________
Is the patient concerned about the appearance of teeth? Y N _____________________________
Is the patient worried about receiving orthodontic treatment? Y N _________________________
Has the patient had any previous orthodontic treatment or consult? Y N ____________________
Does the patient have difficulty in chewing a swallowing food? Y N ________________________
Does the patient have any speech problems? Y N _______________________________________
Does the patient grit, grind, or clench teeth? Y N _______________________________________
Has the patient been a thumb sucker? Until what age? Y N ______________________________
Does the patient breath through their mouth? Y N ______________________________________
Do the gums bleed easily? Y N ____
Has the patient ever received a severe blow to the teeth or jaw? Y N ______________________
Have there been any other injuries to the face, mouth, or teeth? Y N _______________________
Does the patient have frequent earaches or soreness around the ears? Y N __________________
Has the jaw ever locked open or closed? OPEN CLOSED Y N _____________________________
If so when? ________________ How often? ____
Do you consider the patient to be under more stress than most people? Y N _______________
Is the patient an adopted child? Y N ____
Height _________________ Weight _________________
Have tonsils and adenoids been removed? What age? Y N ________________________________
Does the patient have a tendency to colds, sore throats, ear infections? Y N _________________
Please list all medications that the patient is currently taking: _____________________________
____
Please list all drugs/ materials that cause the patient allergic reactions: ____________________
____
Has your son/daughter entered puberty yet? Y N____
For females under age 18, age of first menstruation ____________________________________

Has the patient had/experienced any of the following:

Y N Abnormal Bleeding
Y N AIDS/HIV +
Y N Anemia
Y N Allergies
Y N Asthma
Y N Blood Disorders
Y N Cancer
(If Yes, Date & Type_____________)
Y N Chicken Pox
Y N Lupus

Y N Diabetes
Y N Epilepsy
Y N Fainting
Y N Hearing Impairment
Y N Heart Murmur
Y N Liver Problems
Y N Hepatitis (If Yes, Type_____)
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Congenital Heart Defect

Y N Measles
Y N Scarlet Fever
Y N Sickle Cell Anemia
Y N Skin Rash
Y N Tuberculosis
Other: ______________________
Previous Surgeries:________________
____

I understand that the information I have provided is correct to the best of my knowledge, and that it will be held in the strictest confidence. I also understand it is my responsibility to inform this office of any changes in my child's/my medical or dental status. I understand that where appropriate, credit bureau reports my be obtained.
I authorize release of any information to insurance carriers and to other health care providers involved in my child's/my care, and I authorize payment directly to Dennehy Orthodontics of the insurance benefits, otherwise payable to me. With my informed consent, I authorize the doctor to perform any orthodontic/dental services that may be necessary during treatment.

____ ________________
Authorized Signature of Patient/ Parent or Guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

Consent for Use and Disclosure of Health Information

(To be filed in patient's dental record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my/my child's health information may be used and disclosed as permitted under federal and state law, and outlining my/my child's rights regarding my/my child's health information. By signing this form, I consent to the use and disclosure of my/my child's protected health information to carry out treatment, payment activities, and healthcare operation.

Patient Name:____

Responsible Party Name (if patient less than 18 years old):___________________________________

Responsible Party Relationship to Patient:____

Responsible Party Signature:____________________________________ Date:_________________