SmileMaker™ ORTHODONTICS

1.) ABOUT YOUR CHILD

Today's Date:_____ Date of Birth:_____
Patient's Name:_____ Age:_____
Street Address:_____
City,State,Zip:_____
Home Phone:_____
Other Phone:_____
Email:_____
School Attending:_____ Grade:_____
Interest/Activities in School:_____
Patient's Dentist:_____

2.) WHO IS WITH THE CHILD TODAY?

Name:_____ Relationship:_____
How did you hear about our office?_____
Do you have any family members in treatment here?_____
_____
What do you hope braces will accomplish?(chief complaint)_____
_____
Who will be responsible for making appointments?_____
_____
Have you seen another orthodontist recently?_____
Parent's marital status:_____
Do you have legal custody of the patient?_____
Name and ages of other children in family:_____
_____

3.) MOTHER'S INFORMATION

Mother's Full Name:_____
Street Address:_____
City,State,Zip:_____
Social Security #:_____ D.O.B._____
Home Phone:_____
Work Phone:_____Ext:_____
Other Phone:_____
Employer:_____
Email:_____

4.) FATHER'S INFORMATION

Father's Full Name:_____
Street Address:_____
City,State,Zip:_____
Social Security #:_____ D.O.B._____
Home Phone:_____
Work Phone:_____
Other Phone:_____
Employer:_____
Email:_____

5.) RESPONSIBLE PARTY INFORMATION

Responsible Party's Name:_____
Street Address:_____
City,State,Zip:_____
Social Security #:_____ D.O.B._____
Home Phone:_____
Work Phone:_____Ext:_____
Other Phone:_____
Employer:_____
Email:_____

6.) PRIMARY DENTAL INSURANCE

Do you have orthodontic insurance coverage? ☐Yes ☐No
If yes, name of orthodontic insurance:_____
_____
Mailing Address:_____
City,State,Zip:_____
Policy Holder:_____
Social Security #:_____ D.O.B._____
ID:_____Group #:_____
Employer:_____
I authorize release of any information to the insurance company.
_____
Signature
I authorize payment directly to SmileMaker Orthodontics by my insurance company
_____
Signature

7.) HEALTH HISTORY	8.) PLEASE ANSWER APPROPRIATELY
Do you see your dentist every six months for a cleaning?	Allergic to latex . . . . . ☐ Yes ☐ No
☐ Yes ☐No	Seizures . . . . . ☐ Yes ☐ No
How many times a day do you brush?_____	Diabetes . . . . . ☐ Yes ☐ No
How is your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Heart Murmur . . . . . ☐ Yes ☐ No
Are you under the care of a physician? ☐ Yes ☐ No	Mitral Valve Prolapse . . . . . ☐ Yes ☐ No
If yes, for what reason?_____	Rheumatic Fever . . . . . ☐ Yes ☐ No
_____	Scarlet Fever . . . . . ☐ Yes ☐ No
If you are taking medications, please list:_____	Tuberculosis . . . . . ☐ Yes ☐ No
_____	Asthma . . . . . ☐ Yes ☐ No
_____	Heart Trouble . . . . . ☐ Yes ☐ No
Name of personal physician:_____	Prolonged Bleeding . . . . . ☐ Yes ☐ No
If you are a female, are you pregnant? ☐ Yes ☐ No	Mental Disorder . . . . . ☐ Yes ☐ No
Do you have any drug allergies or sensitivities? ☐ Yes ☐ No	Attention Deficit Disorder . . . . . ☐ Yes ☐ No
If yes, what are they?_____	Scoliosis . . . . . ☐ Yes ☐ No
_____	Fainting or Dizziness . . . . . ☐ Yes ☐ No
_____	Cancer . . . . . ☐ Yes ☐ No
_____	Endocrine Problems . . . . . ☐ Yes ☐ No
Have there been any injuries to face, mouth, or teeth?	Blood Disorders . . . . . ☐ Yes ☐ No
☐ Yes ☐ No	Immunosuppressive Disease (HIV) . . . . ☐ Yes ☐ No
If yes, what?_____	Speech Problems . . . . . ☐ Yes ☐ No
_____	Seasonal Allergies . . . . . ☐ Yes ☐ No
_____	Have tonsils/adenoids been removed? . . . ☐ Yes ☐ No
_____	Do you get frequent headaches? . . . . . ☐ Yes ☐ No
Have you been advised to be pre-medicated? ☐ Yes ☐ No	Does your jaw ever "pop"? . . . . . ☐ Yes ☐ No
If yes, please explain:_____	Has your jaw ever "locked"? . . . . . ☐ Yes ☐ No
_____	Is there any other information that may be helpful?_____
_____	_____
Have you ever been tested or treated for hepatitis? ☐ Yes ☐ No	_____
Does the patient play a musical (wind) instrument? ☐ Yes ☐ No	_____

I authorize the above information to be correct. I understand it is my responsibility to notify SmileMaker Orthodontics of any changes in my child's health history.

_____

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 activates, and healthcare operations.

Notice of privacy practices: We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the cahnges. Those changes may apply to your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, upon request.

Right to Revoke: You will have the right to revoke this consent at any time by giving this office a 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 to continue treating you if you revoke the consent.

SIGNATURE

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 consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, health care operations, and any images can be used for social media and/or educational purposes.

_____ _____

Signature Date