



PATIENT INFORMATION – CHILD

PATIENT

First Name:

Last Name:

Middle Initial:

Prefers to be called:

Sex: male female

Date of Birth:

Phone:

Email:

Home Address:

Primary Responsible Party Information

First Name:

Last Name:

Middle Initial:

Phone:

Email:

Date of Birth:

Relationship to Patient:

Male Female

Home Address:

Secondary Responsible Party Information (optional)

First Name:

Last Name:

Middle Initial:

Phone:

Email:

Date of Birth:

Relationship to Patient:

Male Female

Home Address:

How did you learn about our practice or whom may we thank for referring you?

Referral Source Google Dentist Social Media Sign or billboard Insurance Provider List
 Friend or family Other Website Other

What is your primary concern(s) about your child's teeth?

What is your child's primary concern about their teeth?

How does your child feel about orthodontic treatment (check all that apply)?

Interested Not interested Unsure
 Excited Nervous

Does your child play a musical instrument?

What are your child's hobbies and interests?

Has your child had previous orthodontic treatment? Yes No

If yes, please explain:

Does your child a general dentist they see for cleanings? Yes No

General Dentist Information:

Dental Office Name:

Provider Name:

Any scheduled treatments?

Dental visit in last 6 months?: Yes No

Address:

Do you have Dental Insurance? Yes No

PRIMARY Insurance Information

Primary Insurance Company:

Group Number:

Patient Relationship to Insured: Self Child Spouse Other

Member ID / Policy #:

Insured Full Name:

Insured Date of Birth:

Insured Phone #:

SSN:

Employer:

Insured Address:

Primary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

Do you have additional Dental Insurance coverage? Yes No

SECONDARY Insurance Information

Secondary Insurance Company:

Group Number:

Patient Relationship to Insured: Self Child Spouse Other

Member ID / Policy #:

Insured Full Name:

Insured Date of Birth:

Insured Phone #:

SSN:

Employer:

Insured Address:

Secondary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

Medical History: (include current and previous illnesses)

| | Yes | If yes, Explain |
|--|--------------------------|-----------------|
| NO TO ALL | <input type="checkbox"/> | |
| Anemia | <input type="checkbox"/> | |
| Arthritis or Joint Problems | <input type="checkbox"/> | |
| Asthma/COPD | <input type="checkbox"/> | |
| Bleeding abnormally | <input type="checkbox"/> | |
| Bone fractures/Major Injury | <input type="checkbox"/> | |
| Cancer Treatment | <input type="checkbox"/> | |
| Depression/Mental Health Disturbance | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | |
| Eating Disorder | <input type="checkbox"/> | |
| Emotional, Sensory, Developmental Issues | <input type="checkbox"/> | |
| Endocrine or Thyroid Problems | <input type="checkbox"/> | |
| Epilepsy | <input type="checkbox"/> | |
| Fainting | <input type="checkbox"/> | |
| GERD/Acid Reflux | <input type="checkbox"/> | |
| Headaches/Migraines | <input type="checkbox"/> | |
| Heart problems | <input type="checkbox"/> | |
| Hepatitis | <input type="checkbox"/> | |
| High blood pressure | <input type="checkbox"/> | |
| Kidney Problems | <input type="checkbox"/> | |
| Osteoporosis | <input type="checkbox"/> | |
| Pacemaker | <input type="checkbox"/> | |
| Rheumatic fever | <input type="checkbox"/> | |
| Skin Disorder (other than common acne) | <input type="checkbox"/> | |
| Stroke | <input type="checkbox"/> | |
| Tobacco use | <input type="checkbox"/> | |
| Vision, Hearing, Speech Problems | <input type="checkbox"/> | |

Other/Details:

Has your child had any serious illnesses or operations? Yes No

If yes, please explain:

Dental History:

| | Yes | If yes, Explain |
|---|--------------------------|-----------------|
| NO TO ALL | <input type="checkbox"/> | |
| Thumb/finger sucking | <input type="checkbox"/> | |
| Tongue and/or swallowing problems | <input type="checkbox"/> | |
| Speech problems | <input type="checkbox"/> | |
| Loose teeth or broken fillings | <input type="checkbox"/> | |
| Grinding and/or clenching of teeth | <input type="checkbox"/> | |
| Tonsils and adenoids removed | <input type="checkbox"/> | |
| Crowns/Bridges | <input type="checkbox"/> | |
| Root canals | <input type="checkbox"/> | |
| Mouth breathing | <input type="checkbox"/> | |
| Snoring | <input type="checkbox"/> | |
| History of wearing mouth guard | <input type="checkbox"/> | |
| History of Periodontal disease or treatment | <input type="checkbox"/> | |
| Mouth sores | <input type="checkbox"/> | |
| Injury to face or teeth | <input type="checkbox"/> | |
| Jaw Pain | <input type="checkbox"/> | |
| Clicking or popping jaw | <input type="checkbox"/> | |
| Difficulty opening or closing jaw | <input type="checkbox"/> | |
| Sensitivity when biting | <input type="checkbox"/> | |
| Cold, hot, or sweets sensitivity | <input type="checkbox"/> | |

Has patient reached puberty?
 Yes No
Allergies:

| | Yes | If yes, Explain |
|--|--------------------------|-----------------|
| NO TO ALL | <input type="checkbox"/> | |
| Latex (gloves, balloons) | <input type="checkbox"/> | |
| Metals (jewelry, clothing snaps, etc) | <input type="checkbox"/> | |
| Acrylics | <input type="checkbox"/> | |
| Medication | <input type="checkbox"/> | |
| Environmental: Pollens, Grasses, Weeds, Dust, etc. | <input type="checkbox"/> | |
| Animals | <input type="checkbox"/> | |
| Foods | <input type="checkbox"/> | |
| Other: | <input type="checkbox"/> | |

Some medications may have an effect on dental health and orthodontic treatment. It is important that we are aware of any and all medications your child is taking as they may effect treatment recommendations/options/outcome. List all current medications and the correlating diagnosis:

MedicationFrequencyDiagnosis

Has your child ever taken IV medications for bone disorders or cancer, including but not limited to biphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate), or Didronel (etidronate)? Yes No

If yes, please explain:

Has your child ever taken oral medications for bone disorders, including but not limited to biphosphonates such as Fosamax (aledronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate)? Yes No

If yes, please explain:

What treatment option(s) interest you? Clear Aligners Clear/Metal Braces Retainers

If treatment is recommended, how soon would you like to get started? ASAP Within the week Within the month
 Other

What payment option(s) would you like to review?
 Interest Free Monthly Payment Payment in Full w/Special Courtesy HSA/FSA

Is there anything else you would like us to know before your visit?

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education. Release and Waiver: I authorize release of any information regarding my child's orthodontic treatment to his/her dental and/or medical insurance company.

Signature

Date

iSmile Orthodontics

Privacy Practices

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. Some information may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

We may use and disclose your health information for your treatment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. We may use and disclose your health information in connection with our healthcare operations.

We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information. We will also use our professional judgement in allowing a person to pick up medications, medical supplies, x-rays, or other similar health information.

We may use or disclose your health information to assist in disaster relief efforts. We may use or disclose your health information when we are required to do so by law. We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to authorized federal officials for national security activities. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters). We may also contact you to provide information about treatment alternatives or other health-related information that may be of interest to you.

PATIENT RIGHTS

You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. You will receive notifications of breaches of your unsecured protected health information as required by law. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, please contact us using the contact information listed at the end of this Notice. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's notice of privacy practice, security and breach notification policies and procedures and I understand that I should ask our practice's Privacy Official if I have any questions about these policies and procedures

* Please ensure that you add anyone who could potentially accompany you/your child to future visits and anyone who may be making payments on the account in the future.

Signature: _____

Date: _____

Responsible Party gives permission to release patient information the following additional parties:

(Name) (Relationship to patient)

(Name) (Relationship to patient)

(Name) (Relationship to patient)