Patient Health Form

Tell us about your Child

Date: _____ Nickname: _____

Child's Name: _____

Birth Date: ___/___/___ Age: _____ SS#: _____

School: _____

Hobbies: _____

Home #: _____

Address: _____

_____

Who is Accompanying your Child?

Name: _____ Relation: _____

How did you hear about us?

_____

May we thank this person for referring you? ***Yes*** ☐ ***No*** ☐

General Dentist*: _____

Last Visit/Cleaning*: _____

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated

Parental Information

☐ Mother ☐ Stepmother ☐ Guardian ☐ _____

Do you have legal custody of the child? ***Yes*** ☐ ***No*** ☐

Name: _____ Birth Date: ___/___/___

Wk #: _____ Cell #: _____

Email: _____

You may contact me with: ☐ ***Email*** ☐ ***Phone*** ☐ ***Both***

☐ Father ☐ Stepfather ☐ Guardian ☐ _____

Do you have legal custody of the child? ***Yes*** ☐ ***No*** ☐

Name: _____ Birth Date: ___/___/___

Wk #: _____ Cell #: _____

Email: _____

You may contact me with: ☐ ***Email*** ☐ ***Phone*** ☐ ***Both***

Person Responsible for Account

Name: _____

Billing Address: _____

_____

Previous Address: _____

_____

Hm #: _____ Wk #: _____

Email: _____

Employer: _____

SS#: _____

Please list authorized persons with whom we may discuss your **Protected Health Information (PHI).** *Please notify us if you desire to remove a name from this list in the future.*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Primary Orthodontic Insurance

Orthodontic Coverage? ***Yes*** ☐ ***No*** ☐

Insurance Co. Name: _____

Insurance Co. Address : _____

_____

Insurance Co. Phone #: _____

Group/Policy #: _____

Policy Owner Name: _____

Relationship to Patient: _____

Policy Owner Birth Date: _____

Policy Owner Employer: _____

Employer's Address: _____

Medical History

What can we do to help your child's smile?

_____

_____

Has your child ever taken Phen-Fen? ***Yes*** ☐ ***No*** ☐

Has your child ever been evaluated or had an orthodontic treatment? ***Yes*** ☐ ***No*** ☐

Have there been any injuries to the face, teeth or chin? ***Yes*** ☐ ***No*** ☐

List any musical instrument played: _____

Have adenoids or tonsils been removed? ***Yes*** ☐ ***No*** ☐

Has your child been informed of any missing or extra permanent teeth? ***Yes*** ☐ ***No*** ☐

Has your child ever had any pain or tenderness in their jaw joint? (TMJ/TMD) ***Yes*** ☐ ***No*** ☐

Does your child brush their teeth daily? ***Yes*** ☐ ***No*** ☐

Does your child floss their teeth daily? ***Yes*** ☐ ***No*** ☐

Child's Physician: _____

Phone #: _____ Date of last visit: _____

Is your child under the care of a physician? ***Yes*** ☐ ***No*** ☐

Has puberty begun? ***Yes*** ☐ ***No*** ☐

Has menstruation begun? ***(Girls)*** ***Yes*** ☐ ***No*** ☐

Please describe your child's current physical health: ***Good*** ☐ ***Fair*** ☐ ***Poor*** ☐

Please list all medications that your child is currently taking:

_____

_____

Has your child had any of the following medical problems?

Y ☐ ***N*** ☐ Abnormal Bleeding	***Y*** ☐ ***N*** ☐ Diabetes
Y ☐ ***N*** ☐ ADD/ADHD	***Y*** ☐ ***N*** ☐ Handicaps/Disabilities
Y ☐ ***N*** ☐ Allergies to any Drugs	***Y*** ☐ ***N*** ☐ Hearing Impairment
Y ☐ ***N*** ☐ Any Hospital Stays	***Y*** ☐ ***N*** ☐ Heart Murmur
Y ☐ ***N*** ☐ Any Operations	***Y*** ☐ ***N*** ☐ Hemophilia
Y ☐ ***N*** ☐ Artificial Bones/Joints	***Y*** ☐ ***N*** ☐ Hepatitis
Y ☐ ***N*** ☐ Artificial Valves	***Y*** ☐ ***N*** ☐ HIV+/AIDS
Y ☐ ***N*** ☐ Asthma	***Y*** ☐ ***N*** ☐ Kidney/Liver Problems
Y ☐ ***N*** ☐ Cancer	***Y*** ☐ ***N*** ☐ Lupus
Y ☐ ***N*** ☐ Congenital Heart Defect	***Y*** ☐ ***N*** ☐ Rheumatic/Scarlet Fever
Y ☐ ***N*** ☐ Convulsions/Epilepsy	***Y*** ☐ ***N*** ☐ Tuberculosis

Please list any allergies your child has (including drugs/food):

_____

_____

Latex ***Y*** ☐ ***N*** ☐ *Metals* ***Y*** ☐ ***N*** ☐ *Plastics* ***Y*** ☐ ***N*** ☐

Please discuss any additional information of medical issues:

_____

_____

Has your child ever experienced any of the following?

Y ☐ ***N*** ☐ Tongue Thrust	***Y*** ☐ ***N*** ☐ Nursing/Bottle Habits
Y ☐ ***N*** ☐ Lip Sucking/Biting	***Y*** ☐ ***N*** ☐ Speech Problems
Y ☐ ***N*** ☐ Mouth Breathing	***Y*** ☐ ***N*** ☐ Thumb/Finger Sucking
Y ☐ ***N*** ☐ Nail Biting	***Y*** ☐ ***N*** ☐ Clenching/Grinding Teeth

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, CDC and ADA.

OFFICE USE ONLY

I verbally reviewed the information above with the parent/guardian and patient.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Printed Name *of Parent or Guardian* *Date*

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and is my responsibility to inform this office of any changes in my child's medical status. I authorize the staff to perform the necessary services that my child may need.

_____ _____

Signature of Parent or Guardian *Date*

I received a copy of the Notice of Privacy Practices of Sakowitz Smiles Orthodontics. I hereby authorize, as indicated by my signature, Sakowitz Smiles Orthodontics to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent Form.

_____ _____

Signature of Parent or Guardian *Date*

If this office accepts insurance, I understand that I am responsible for payment of services rendered. I am also responsible for paying any co-payment/deductibles that my insurance does not cover. I hereby authorize payment of group insurance benefits directly to this office.

_____ _____

Signature of Parent or Guardian *Date*

PATIENT CONSENT

Clinical

1. I authorize Sakowitz Smiles Orthodontics, to perform all recommended treatment. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

2. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

3. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

4. A $25 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hour notice of cancellation is required.

Insurance

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

6. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____
Patient's Address: _____
Patient's Signature: _____

If patient is a child, please provide the parental or legal guardian's consent:
Signature: _____ Relationship: _____ Date: _____