The Silver Spring Orthodontist

"for the smile of a lifetime"

ORTHODONTIC PATIENT INFORMATION

Welcome to our office. The following information is requested so we may be of maximum service to you and to thoroughly diagnose your child's orthodontic problem during the initial consultation. This information is confidential. Thank you.

Patient's Name: _____ **Age:** _____ **Birthdate:** _____ **Sex:** _____

Home Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip Code:** _____

Patient's School Level: _____ **School Name:** _____

Parent #1 Name: _____ Home Phone: _____

Employer: _____ Occupation: _____ Business Phone: _____

SS#: _____ DOB: _____ Cell Phone: _____

E-Mail Address: _____

Parent #2 Name: _____ Home Phone: _____

Employer: _____ Occupation: _____ Business Phone: _____

SS#: _____ DOB: _____ Cell Phone: _____

E-Mail Address: _____

Person Responsible for Account: _____

Please provide the following information, if different from above:

Home Address: _____ City: _____ State _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

Is patient covered by orthodontic insurance? ☐ Yes ☐ No If yes, by which company? _____

Name of person to be contacted if patient cannot be reached:

Name: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

Patient's General Dentist: _____ Family Physician: _____

How did you hear about us? _____

FAMILY STATUS:

Number of Siblings: _____ Number of Brothers: _____ Number of Sisters: _____

Other Family Members with similar orthodontic condition:

☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Other: _____

Parent's Marital Status: _____ Patient Living With: _____

MEDICAL / DENTAL HISTORY:

Present Health: ☐ Good ☐ Fair ☐ Poor Currently Under Treatment: ☐ Yes ☐ No

Specify: _____

Present Drugs or Medication: _____

Has patient been under the care of a physician during the past two years other than routine examination? ☐ Yes ☐ No

Specify: _____

Birth Defects: ☐ Yes ☐ No Specify: _____ Does patient smoke? ☐ Yes ☐ No

Has the patient ever had (check all that apply)?

☐ Asthma	☐ Diabetes	☐ Heart Disease
☐ Anemia	☐ Epilepsy	☐ Hearing Disorder
☐ Blood Disease	☐ Endocrine Problems	☐ Head or Face Injury
☐ Bone Disorders	☐ Emotional Problems	☐ Rheumatic Fever

Comments: _____

Does the patient:

1. Have allergies to: Seasonal Grasses: _____ Food: _____
   Drugs: _____ Other: _____
2. Snore when sleeping? ☐ Yes ☐ No
3. Breathe through their mouth? ☐ Seldom ☐ Sometimes ☐ Usually
4. Have frequent colds? ☐ Yes ☐ No
5. Have frequent sore throat or tonsillitis? ☐ Yes ☐ No
6. Have chewing or swallowing difficulty? ☐ Yes ☐ No

Has the patient received medical treatment from an allergist or ear, nose and throat specialist? ☐ Yes ☐ No

If yes. When? _____ By Whom? _____ ☐ Tonsils Removed ☐ Adenoids Removed

Does patient have pain or clicking in jaw? ☐ Yes ☐ No

Have any teeth been inured due to accidents or blows to the mouth? ☐ Yes ☐ No

Has the patient received or been requested to receive speech correction? ☐ Yes ☐ No

Thumb sucking until age: _____ Grinding of teeth? ☐ Yes ☐ No

Finger sucking until age: _____ Tongue thrusting? ☐ Yes ☐ No

Lip biting or sucking? ☐ Yes ☐ No Other habits? ☐ Yes ☐ No

Has patient had any unusual dental experiences? ☐ Yes ☐ No

Specify: _____

Has the patient had previous orthodontic consultation or treatment? ☐ Yes ☐ No

Date: _____ Doctor: _____

Are there any other medical, dental or surgical problems not covered above? ☐ Yes ☐ No

Specify: _____

PATIENT'S ATTITUDE TOWARD TEETH, FACE, AND ORTHODONTIC TREATMENT:

Dental Checkups: ☐ Twice a Year ☐ Once a Year ☐ Only if Urgent ☐ Never

Date of last dental checkup? _____ Were the patient's teeth cleaned? ☐ Yes ☐ No

Patient's interest in orthodontic treatment?

☐ Wants Treatment ☐ Treatment if Necessary ☐ Unwilling but Agrees ☐ Uncooperative

Why did the patient seek consultation? _____

What is the primary problem? _____

Additional Comments you wish to make: _____

Signature of individual completing this form: _____ Completion of this field serves as signature Date: _____

Relationship to Patient _____

ORTHODONTIC INSURANCE INFORMATION

DATE: _____ **PATIENT NAME:** _____ **DATE OF BIRTH:** _____

SUBSCRIBER / EMPLOYEE INFORMATION

Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip Code: _____

Social Security: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Policy / Group #: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Adult Coverage: ☐ Yes ☐ No

For Office Use Only:

Lifetime Max: _____ Paid at: _____ % How Paid: A S Q M _____ Auto Pay: ☐ Yes ☐ No

Benefit Used: _____ **Deductible:** _____

If patient is covered by another dental plan, please complete the following information:

SUBSCRIBER / EMPLOYEE INFORMATION

Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip Code: _____

Social Security: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Policy / Group #: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Adult Coverage: ☐ Yes ☐ No

For Office Use Only:

Lifetime Max: _____ Paid at: _____ % How Paid: A S Q M _____ Auto Pay: ☐ Yes ☐ No

Benefit Used: _____ **Deductible:** _____

I hereby authorize release of any information relating to this claim:

Signature: Completion of this field serves as signature Date: _____

I hereby authorize payment of the insurance benefits directly to the below named orthodontist:

Signature: Completion of this field serves as signature Date: _____

THE SILVER SPRING ORTHODONTIST

PATIENT CONSENT / ACKNOWLEDGEMENT FORM

Patient's Name: _____

By signing below, you have given consent for the use and disclosure of your protected health information by Dr. Duane Erickson and Dr. Jean Hong, The Silver Spring Orthodontist, our staff and our business associates for treatment, payment and health care operations. Please review our Notice of Privacy Practices displayed in our office. If the terms do change it will be displayed in our waiting area. You may refuse to consent to the use or disclosure of your Protected Health Information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand, and agree to the content of the notice of privacy:

Print Name: _____

Signature: Completion of this field serves as signature Date: _____

If you choose not to sign the CONSENT / ACKNOWLEDGEMENT OF NOTICE OF PRIVACY, please specify why:

_____

_____

_____

_____

_____

_____

ALL FORMS ARE SUBJECT TO CHANGE IN THE FEDERAL LAW AND APPLICABLE STATE LAWS.