ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ______________________ have received a copy of this office's Notice of Privacy Practices.

X ______________________ ____________
Patient/Parent or Guardian Date

ADDENDUMS TO THE CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

ADDENDUM I

From time to time, it may be necessary to communicate your health care information or status to referring dentists or physicians. This make take the form of letter or postcard, emails, phone conversations, or other forms of communication that may or may not reveal pertinent information about your health status or your treatment received in this office. You consent to allow this office to continue to provide information to necessary health care providers.

X ______________________ ____________
I AGREE DATE

ADDENDUM II

From time to time, pertinent information concerning your health, your treatment progress, your referring dentist, or your insurance carrier may appear on the front of your orthodontic chart. This information is for internal use alone and is designed to protect the patient and enhance your treatment and treatment progress. However, even though precautions are taken to insure your privacy, it may or may not be seen by unauthorized individuals. You allow this office to continue this practice.

X ______________________ ____________
I AGREE DATE

PATIENT REGISTRATION

Name ______________________ Date ____________

Date of Birth ____________ Age ______

Address ______________________

City ____________ State ____________ Zip ____________

Home Phone # ____________ Cell Phone # ____________

Email address ______________________

Dentist ____________ Last visit ________ Referred by ____________

Dental Insurance Co. ____________ Subscriber ____________

Subscriber Date of Birth ____________ Member ID/SSN ____________

IF ADOLESCENT:

Father's name ____________ Home/Cell Phone ____________

Address ______________________

Mother's name ____________ Home/Cell Phone ____________

Address ______________________

School ____________ Hobbies/Activities ____________

MEDICAL HISTORY

1) Date of last physical or medical check-up ____________
2) Is the patient in good health? ____________
3) Is the patient under a physician's care now? If "yes" please explain: ____________
4) Is the patient on any medication? If "yes" please list: ____________
5) Has the patient had any history of the following: (Please circle)

(a) Allergies/Asthma	(e) Tonsilitis	(i) Anemia
(b) Rheumatic Fever	(f) Diabetes	(j) Heart trouble/Heart murmur
(c) Hepatitis	(g) Epilepsy	(k) Kidney/Liver trouble
(d) TB	(h) HIV/Aids	(l) Prolonged bleeding

6) Has the patient had any unusual reactions to anesthetic (i.e. Penicillin, Aspirin, Tylenol, Motrin, Codeine)? ____________
7) Is there any information we should know about the patient's health? ____________
8) Has the patient experienced any unfavorable or undesirable reaction from previous dental or medical care? ____________
9) Has the patient ever had any hearing, sight, speech or special schooling problem? ____________
10) List any habits the patient may have - i.e. thumb-sucking, mouth breathing, nail biting, etc. (past or present) ____________
11) Has the patient had any prior orthodontic consultations or treatment? ________ If so, when? ____________

SIGNATURE (Parent if patient is a minor) X ______________________

Name: ________________________ **Age:** _____ **Sex:** ____ **Date:** _______ **Seen by: DR.**__________________

1. Profile: _______________

DOB: ____/____/_____

2. Dentition

Dentist:

____

Right															Left
		6											6		
		6											6		

3. Angle Classification

	Right side		Left side	
	Molar	Canine	Molar	Canine
Class I				
Class II				
Class III				

4. Overbite: ____Normal ____Deep ____Open ____%

5. Overjet: ____ Normal ____Severe ____Under bite ____mm

6. ALD: Maxillary:

- ☐ Crowding ____
- ☐ Adequate
- ☐ Space ____

Mandibular:

- ☐ Crowding ____
- ☐ Adequate
- ☐ Space ____

7. Midlines:

8. Cross bite: None ________

Anterior ________ Posterior ________

9. Abnormal Frenum: _________________________

10. Oral Hygiene: _________________________

11. Maxillary Midline Diastema: ___ **Yes** ___**No**

12. Mandibular Posturing: ___ **Yes** ___**No**

13. Tongue Thrust: ___ **Yes** ___**No**

NOTES:

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TREATMENT PLAN:

____

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ESTIMATED TREATMENT TIME:

____________________ months

Letter to patient sent ☐

Letter to dentist sent ☐

Referral letter sent ☐