WELCOME

To Your Orthodontist!

Tell Us About Your Child

Today's Date: ____/____/____ Nickname: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/___ Child's Age: ___ ☐ Male ☐ Female

E-mail Address: _____

School: _____ Grade: _____

Hobbies/sports: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

Other siblings/ages: _____

General Dentist: _____ Last Visit Date: _____

Dentist's Phone: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____

_____
City State Zip

Parent's Information

Who is responsible for account? _____ Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Mother ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (____)_____ Ext: _____ Cell #: (____) _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____)_____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

☐ **Mother** ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (____)_____ Ext: _____ Cell #: (____) _____

Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

If you have Orthodontic Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____)_____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

CONTINUED ON BACK

Dental & Medical History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

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

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

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Does your child have any missing or extra permanent teeth? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things your child is allergic to:

_____

_____

Y N Latex Y N Nickel/Metals Y N Plastic

Has the child experienced the following medical problems?

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N AIDS/HIV+
Y N Any Hospital Stays/Operations
Y N Artificial Bones/Joints/Valves
Y N Asperger Syndrome
Y N Asthma
Y N Autism
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Kidney Problems
Y N Liver Problems
Y N Mitral Valve Prolapse
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Sickle Cell Disease/Traits
Y N Tuberculosis (TB)

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? _____ ☐ Yes ☐ No

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child has had:

_____

_____

Does/did the child experience any of the following?

Y N Breast Fed
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust
Y N Used Pacifier

List any musical instruments played: _____

_____

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

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

_____
Signature of Parent or Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____
Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

_____

_____
Parent/Guardian Signature Date

_____
Dentist Signature Date

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

_____

_____
Parent/Guardian Signature Date

_____
Dentist Signature Date

AUTHORIZED PATIENT NOTIFICATION LIST

(Required of HIPAA) Health Insurance Portability and Accountability

I authorize all Wiregrass Orthodontic Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my orthodontic care, to include: appointments, financial obligations, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people:

_____ _____

_____ _____

_____ _____

_____ _____

This document will be part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

_____ _____

Patient/Other Person Authorized to Sign **Date**

_____ _____

Relation to Above Signature **Date**

_____ _____

Witness Signature **Date**

Wiregrass Orthodontic Specialists

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Patients Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ Social Security #: _____

Section B: ***TO THE PATIENT---PLEAE READ THE FOLLOWING STATEMENT CAREFULLY***

Purpose of Consent: By signing this form, you will consent our use and disclosure of your protected health information to carry out treatment, payment activities, and health operations.
Notice of Privacy Practices: you have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 rived Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue if you revoke this Consent.

Contact Officer
Hillary Franks
(334) 792-1000

Wiregrass Orthodontic Specialists
100 O'Brannan Park Drive
Dothan, AL 36303
(334) 792-1000

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 and health car operations.

Signature: _____Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed consent in the patient's chart

Wiregrass Orthodontic Specialists

Acknowledgement of Receipt of Notice of Privacy Practices

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

_____
Please Print Name

_____
Signature

_____
Date

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An Emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____