Johnson Orthodontics

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____
Last First MI

SS #: _____

Birthdate: _____/_____/_____ Age: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____)_____

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

2 Who is accompanying your child today?

Name: _____ Relation: _____

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

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

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

3

☐ **Mother's Information:** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: _____/_____/_____

E-mail Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____Wk #: (____)_____ Ext: ____

SS #: _____ DL #: _____

☐ **Father's Information:** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: _____/_____/_____

E-mail Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____Wk #: (____)_____ Ext: ____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: ☐ Mom ☐ Dad ☐ Other

(If other, please complete)

Billing Address: _____

_____
City State Zip

Do you Own or Rent? (circle one) How Long? _____

Hm #: (____)_____ DL #: _____

Cell #: (____)_____ SS #: _____

Employer: _____Wk #: (____)_____ Ext: ____

Who is responsible for making appointments?

Name: _____

Preferred contact number: ☐ Home ☐ Cell ☐ Work

5 Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

CONTINUED ON BACK

6

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

_____

Has your child ever taken Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) if yes, when? _____

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

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

List any musical instruments played: _____

Have the 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 / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

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

Floss his / her teeth daily? ☐ Yes ☐ No

Child's physician: _____

Phone #: (_____)_____ Date of Last Visit: _____

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

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

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

Please list all of the drugs that your child is currently taking: _____

_____

Please list all of the drugs / things that your child is allergic to: _____

_____

Latex Y N **Metals / Nickel Y N** **Plastics Y N**

7 Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to Any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergies to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/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	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

8 Has your child ever experienced any of the following?

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

9 Thank you for filling out this form completely.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

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 the office, use the services of one or more credit reporting services.

_____
Signature **Date**

I authorize the dental staff to perform any necessary dental services my child may need.

_____
Signature **Date**

The Parent or Guardian who accompanies the child is responsible for payment.

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.

OFFICE USE ONLY

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

Doctor's Comments: **Initials: _____ Date: _____**

_____

_____

_____

Johnson Orthodontics

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

• To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);

• To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

• To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;

• Internally, to all staff members who have any role in your treatment;

• To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;

• To your family and close friends involved in your treatment; and/or,

• We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:
• Request restrictions on the use and disclosure of your protected health information;
• Request confidential communication of your protected health information;
• Inspect and obtain copies of your protected health information through asking us;
• Amend or modify your protected health information in certain circumstances;
• Receive an accounting of certain disclosures made by us of your protected health information; and,
• You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:
• By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
• To abide by the terms of our Privacy Notice that is currently in effect; and,
• To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:
• Honor any request by you to restrict the use or disclosure of your protected health information;
• Amend your protected health information if, for example, it is accurate and complete; or,
• Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT
I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____
Signature of Patient/Parent/ Guardian Date