sound orthodontics

Date _____

CHILD'S INFORMATION

Patient Name: _____ Sex: M/F Birth Date _____/_____/_____
Preferred Name (Nickname): _____ SSN: _____ - _____ - _____
School currently attending: _____ Current grade: _____
Whom may we thank for referring you to our office? _____
Patient's Dentist: _____
Reason for today's visit? (in your own words)_____
_____

RESPONSIBLE PARTY / GUARDIANS

Name: _____
Relationship to patient:_____
DOB _____ /_____ /_____ SSN: _____- ____ - _____
Physical address_____
City:_____ zip code:_____
Preference for contact: Text or Email **(circle one or both)**
Cell Phone: (_____) _____ - _____
Cell phone carrier (for text msgs)_____
Email address:_____
Work Phone: (_____) _____-_____
Marital status:(circle): Single / Married / Divorced / Domestic Partner / Widowed
Employer:_____How long?_____
Occupation/Job title: _____

Name: _____
Relationship to patient:_____
DOB _____ /_____ /_____ SSN: _____- ____ - _____
Physical address_____
City:_____ zip code:_____
Preference for contact: Text or Email **(circle one or both)**
Cell Phone: (_____) _____ - _____
Cell phone carrier (for text msgs)_____
Email address:_____
Work Phone: (_____) _____-_____
Marital status(circle): Single / Married / Divorced / Domestic Partner / Widowed
Employer:_____How long?_____
Occupation/Job title: _____

INSURANCE INFORMATION (DENTAL ONLY)

Primary Dental Insurance

Insurance company:_____
Subscriber's Name: _____
DOB _____ /_____ /_____
Member ID#:_____
Group # _____
Insurance Phone # (_____) _____ - _____
Patient's relation to subscriber: _____

Secondary Dental Insurance

Insurance company:_____
Subscriber's Name: _____
DOB _____ /_____ /_____
Member ID#:_____
Group # _____
Insurance Phone # (_____) _____ - _____
Patient's relation to subscriber: _____

EMERGENCY CONTACT (person not living with patient ie: close family friend or relative)

Name:_____ Relation to patient: _____
Address: _____
Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

The information that I have given is correct to the best of my knowledge

Parent Signature _____ Date_____

HEALTH QUESTIONNAIRE

Medical Physician's Name: _____ Physician's Phone # (_____) _____-_____

Date of last physical: _____ (**Women**: are you, or could you be pregnant)? Y/N

Currently under physician's care for the following: _____

Has the patient been hospitalized? If yes, please explain _____

Does the patient now, or has the patient ever had any of the following diseases or conditions?

Please circle Yes or No in response to the following questions. Your answers will be CONFIDENTIAL.

ADD or ADHD	Yes	No	Hypertension	Yes	No
AIDs (HIV positive)	Yes	No	Kidney Disease or Infection	Yes	No
Anxiety Disorder	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Painful or Swollen Joints	Yes	No
Autism	Yes	No	Prosthetic Valves, Joints or Screws	Yes	No
Blood Disorders or Transfusions	Yes	No	Radiation Treatment	Yes	No
Diabetes	Yes	No	Severe Headaches	Yes	No
Epilepsy or Seizures	Yes	No	Stroke	Yes	No
Heart Attack	Yes	No	Tonsils or Adenoids Removed	Yes	No
Hemophilia	Yes	No	Tuberculosis	Yes	No
Hepatitis (A, B, or C)	Yes	No	Tumor or Growth	Yes	No
Herpes	Yes	No	Ulcer or Acid Reflux	Yes	No

Has the patient ever been told by a physician that they have a heart murmur? Y/N

Has a physician or dentist recommended pre-medication with antibiotics before dental treatment? Y/N

Has the patient ever had any heart trouble, artificial valves, or rheumatic fever? Y/N

Does the patient now, or has the patient ever used tobacco products? Y/N

Has the patient ever taken medication for osteoporosis? Y/N Name of medication: _____

Does the patient have any **allergies (to latex, metals, etc.)?** Y/N **Please list**_____

Has the patient experienced any unusual **reactions or allergies** to any of the following drugs?

Penicillin	Yes	No	Dental Anesthetic	Yes	No
Antibiotics	Yes	No	Sulfa Drugs	Yes	No
Aspirin	Yes	No	Others, please list :		

Please list all current medication and/or herbal supplements the patient is taking:

_____

_____

DENTAL HISTORY

Does the patient have a history of any of the following?

Missing or extra teeth	Yes	No	TMJ problems	Yes	No	History of thumb sucking	Yes	No
Chipped or injured teeth	Yes	No	Clenching or Grinding	Yes	No	Abnormal swallow	Yes	No
Jaw fractures	Yes	No	Loose or shifting teeth	Yes	No	Negative dental experience	Yes	No
Damaged or lost fillings	Yes	No	Periodontal disease	Yes	No	Is all dental work complete?	Yes	No

Has the patient had previous orthodontic treatment? Y/N

**I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that the questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any later changes to this history, medical, or dental status, I will inform the practice.

_____

Signature (Parent's signature if minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Sound Orthodontics - Tukwila. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Sound Orthodontics - Tukwila reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number:	**Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	