Date: _____

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City: _____ State TX Zip Code: _____

Phone Number: _____ Email Address: _____

Birth Date: _____ Social Security Number: _____

If Patient is a Minor, give Parent's or Guardian's Full Name: _____

Brothers and/or Sisters (names & ages): _____

Whom may we thank for referring you to our office? _____ Who is your General Dentist? _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City: _____ State TX Zip Code: _____

Yrs At This Address? _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Previous Address (if less than 3 yrs) _____

Marital Status: _____ Social Security Number: _____ Birth Date: _____

Relationship with Patient: _____

Employer: _____ Occupation: _____ No. of years employed: _____

Spouse's Last Name: _____ First Name: _____ MI: _____

Spouse's Employer: _____ Occupation: _____ No. of years employed: _____

Social Security Number: _____ Birth Date: _____ Work/Cell Phone: _____

INSURANCE INFORMATION

Insured's Last Name: _____ First Name: _____ Subscriber ID: _____

Insured's Address: _____

Street Address City State Zip Code

Insurance Company: _____ Group No: _____ Local No: _____

Insurance Address: _____ City: _____ State TX Zip Code: _____

Dual Coverage ◯ Yes ◯ No If yes, full name of covered person: _____

Insured's Employer: _____

As a courtesy to our patients, we file your insurance claim forms. We will attempt to obtain as much insurance coverage for you as possible. However, please understand that you are responsible, in full, for all charges rendered. Any insurance estimates provided by this office shold be considered a guideline only. When final insurance payment is received, your account will be reconciled. I authorize the release of any information necessary to process my insurance claims and, also, hereby authorize payment of insurance benefits to ClearChoice Orthodontics.

Signature: _____ Date: _____

MEDICAL HISTORY

Your answers to the following questions are extremely important for an accurate diagnosis. Thank you for your patience in answering the following questions:

Patient's Name: _____ Nickname: _____

1. Has the patient recently (within the past year) received treatment from a medical professional? ☐ Yes ☐ No
   If yes, for what? _____
2. Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No ☐ Nursing? ☐ Taking oral contraceptives?
3. Is the patient taking any medications? ☐ Yes ☐ No If yes, name medications: _____
4. Has the patient ever had: (please check all that apply)

   ☐ Rheumatic fever ☐ Heart disease ☐ Diabetes ☐ Asthma
   ☐ Hay fever ☐ Allergies (seasonal) ☐ Convulsions ☐ Positive HIV test (AIDS)
   ☐ Tonsilitis ☐ Hepatitis ☐ Prolonged bleeding ☐ Photosensitivity or Glaucoma
5. Have you had any major operations? ☐ Yes ☐ No
   If yes, what? _____
6. Are you allergic to the following?

   ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics Other: _____

DENTAL HISTORY

1. Has the patient ever received a severe blow to the teeth or jaws? ☐ Yes ☐ No
   If so, where? _____
2. Has the patient been to a dentist in the last 12 months? ☐ Yes ☐ No
3. Does the patient constantly have sore or bleeding gums? ☐ Yes ☐ No
4. Have any of the patient's teeth been removed? ☐ Yes ☐ No ☐ Baby teeth ☐ Permanent
5. Has the patient ever sucked fingers, thumb, lips or tongue? ☐ Yes ☐ No
   Is the patient still or at what age did it stop? _____
6. Does the patient play a wind musical instrument? ☐ Yes ☐ No If so, what kind: _____
7. Who first noticed the need for orthodontic treatment ? _____
8. Has another member of the family had orthodontic treatment? ☐ Yes ☐ No If so, who: _____
9. Has the patient ever had "braces" before? ☐ Yes ☐ No
10. Does any member of the family or close relatives have a similar arrangement of teeth or similar appearance of jaws?

    ☐ Yes ☐ No If so, who: _____
11. Is the patient interested in: (please check all that apply)

    ☐ Appearance ☐ Better speech ☐ On advice of friends ☐ On advice of dentist
    ☐ TMJ ☐ Other
12. Is the patient dissatisfied with the appearance of their teeth? ☐ Yes ☐ No

If so, please describe what the patient would like to have fixed:

DENTAL HISTORY cont'd

If you are filling this out for a minor, are you concerned about the appearance of their teeth? If so, please describe what you would like to have fixed:

13. Is the patient dissatisfied with the appearance of their facial features (nose, chin, jaw, etc.)? ☐ Yes ☐ No

If so, what in particular: _____

14. Has the patient ever been teased about the appearance of their teeth or face? ☐ Yes ☐ No

Please take this space to give us any comments or information you feel may be pertinent to the patient's situation in regards to corrective dental procedures

NOTE: We make every attempt to schedule appointments for convenience, but orthodontic appointments may infringe on your school/ work schedule.

Please type your initials indicating that you understand about appointment scheduling: _____

I understand that records are stored electronically and that an electronic copy shall be considered an original for all purposes.

This form filled out by: _____ Date: _____

Please sign: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION.

By law, we are required to provide you with our Notice of Privacy Practice. Please sign below acknowledging your receipt of this information. This shall also serve as consent to use and/or disclose your protected health information to carry out treatment, payment activities, and health care operations. If you should have any questions regarding this Notice and Consent, you may contact:

ClearChoice Orthodontics at 281-587-4900

Patient, Parent or Legal Representative (please print): _____

Patient, Parent or Legal Representative (signature): _____

Date: _____ ☐ Patient refused to sign ☐ Patient unable to sign

Comments