PATIENT INFORMATION | child

Date: _____

Patient Name: _____ Gender: ☐M ☐F
Last First Middle

Nickname: _____ Birthdate: _____ Age: _____

Mailing Address: _____
Street City State Zip Code

Preferred Phone: _____ ☐Home ☐Cell ☐Mom ☐Dad Email: _____

Whom may we thank for referring you to our office? _____

What school is patient currently attending? _____ Grade: _____

Does patient have any siblings? (Names and Ages) _____

PRIMARY RESPONSIBLE PARTY

Parent/Guardian Name: _____ Marital Status: _____
Last First Middle

SS # _____ Birthdate: _____ Relationship to Patient: _____

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Employer: _____ Occupation: _____ Years Employed: _____

SECONDARY RESPONSIBLE PARTY

Parent/Guardian Name: _____ Marital Status: _____
Last First Middle

SS # _____ Birthdate: _____ Relationship to Patient: _____

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Employer: _____ Occupation: _____ Years Employed: _____

PRIMARY INSURANCE

Policy Holder Name: _____

SS# _____ Birthdate: _____

Company Name: _____

Group # _____

Member ID # _____

Insurance Phone # _____

SECONDARY INSURANCE

Policy Holder Name: _____

SS# _____ Birthdate: _____

Company Name: _____

Group # _____

Member ID # _____

Insurance Phone # _____

EMERGENCY CONTACT INFORMATION

Name of nearest family member/friend not living with you: _____

Relation: _____ Phone # _____

Address: _____
Street City State Zip Code

TRUMAN
ORTHODONTICS

MEDICAL/DENTAL | history

MEDICAL HISTORY

1. Is patient in good health? ☐Y ☐N
2. History of major illness? ☐Y ☐N
   If yes, please list: _____
3. Are there any mental, physical, or social disabilities we should be aware of? ☐Y ☐N
   If yes, please list: _____
4. Is patient currently on any medications? ☐Y ☐N
   If yes, please list: _____
5. Is patient allergic to any medications or substances including metal? ☐Y ☐N
   If yes, please list: _____
6. Does patient use tobacco? ☐Y ☐N
7. For female patients only: Is patient pregnant, or think she may be? ☐Y ☐N
8. Please check all that apply:

☐ Acid reflux	☐ Cardiac pacemaker	☐ High/Low blood pressure	☐ Respiratory problems
☐ AIDS/HIV	☐ Cold sores	☐ Joint replacement	☐ Rheumatic fever
☐ Allergies/Hay Fever	☐ Diabetes	☐ Kidney/Liver disease	☐ Sinus problems
☐ Anemia	☐ Epilepsy/Seizures	☐ Leukemia	☐ Stroke
☐ Asthma	☐ Fainting	☐ Migraines	☐ Thyroid problems
☐ Bone disorders	☐ Heart problems	☐ Osteoporosis	☐ Tonsil/Adenoid removal
☐ Cancer	☐ Hepatitus	☐ Radiation therapy	☐ Ulcers

DENTAL HISTORY

Dentist: _____ Date of last cleaning: _____

1. Does patient get anxious or nervous about dental treatment? ☐Y ☐N
2. Is premedication required before dental work? ☐Y ☐N
3. Any sores or lumps present near mouth? ☐Y ☐N
4. Are there any ongoing problems with jaw with:
   Clicking/popping? ☐Y ☐N Pain? ☐Y ☐N Difficulty opening/closing? ☐Y ☐N Difficulty chewing? ☐Y ☐N
5. Does patient clench or grind teeth? ☐Y ☐N
6. Does patient bite lips or cheeks frequently? ☐Y ☐N
7. Has patient ever had speech therapy? ☐Y ☐N
8. Does patient have any of the following oral habits:

☐ Mouth breathing	☐ Nail biting	☐ Thumbsucking	☐ Tongue thrust

9. Please check what problems/concerns patient is seeking treatment for:

☐ Crowding	☐ Missing/Extra teeth	☐ Teeth stick out	☐ TMJ problems
☐ Extra space	☐ Poor bite	☐ Teeth erupting in wrong position	

☐ Other: _____

AUTHORIZATION & RELEASE

_____ Initial
I understand that the information that I have given is correct to the best of my knowledge; that it will be held in strictest of confidence and it is my responsibility to inform this office of any changes. I authorize the dental staff to perform the necessary dental services.

_____ Initial
Truman Orthodontics reserves the right to verify the credit status of potential patients and/or responsible party prior to extending any third-party financing.

_____ _____
Signature (Parent/Guardian if minor) Date

TRUMAN ORTHODONTICS

Patient Acknowledgement of Receipt of Notice of Privacy Practices & Consent/Limited Authorization & Release Form

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

By signing below, I acknowledge receipt of a copy of the Notice of Privacy Practices for Truman Orthodontics. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI (Personal Health Information) document release should I request treatment or radiographs be sent to other attending doctors/facilites in the future.

_____ _____

Please **print** name of patient | Please **sign** for Patient/Guardian of Patient

_____ _____

Legal Representative/ Guardian | Relationship of Legal Representative / Guardian

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I authorize contact from this office to confirm my appointments via:

□ Text Message to my Cell Phone _____

I authorize information about my health, treatment & billing be conveyed via:

□ Cell Phone _____ □ Text Message to my Cell Phone _____

□ Home Phone _____ □ Email _____

□ Work Phone _____ □ **Any of the above**

I approve being contacted about special services, events & fund raising efforts or new health info on behalf of Truman Orthodontics via:

□ Phone Message _____ □ **Any of the Above**

□ Text Message _____ □ **None of the Above - opt out**

□ Email _____

I hereby grant Truman Orthodontics permission to use in perpetuity the photographs/radiographs/professional photographs that are in the patient's file in connection with education, promotion, advertising and/or social media.

_____ _____

Patient/Guardian Signature | Relationship to patient

In signing the HIPPA Patient Acknowledgement Form, you acknowledge and authorize that Truman Orthodontics may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

For Office Use Only

As Privacy officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

□ It was emergency treatment

□ I could not communicate with the patient

□ The patient refused to sign

□ The patient was unable to sign because:

□ Other:

_____ _____

Signature of Privacy Officer

_____