American Association of Orthodontists.

My Life. My Smile. My Orthodontist.®

CONFIDENTIAL

Medical Dental History Form for Patients Under Age 18

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Sex ☐ Male ☐ Female Social Security# _____

School _____ Grade _____ Email address(es) _____

Home address _____ City, State, Zip code _____

Home phone ( ) _____ - _____ Cell phone ( ) _____ - _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with *(check all that apply)* ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

Father's full name _____ Title: ☐ Mr ☐ Dr ☐ Other _____

Occupation _____ Email address _____

Address *(if different)* _____

Home phone *(if different)* ( ) _____ - _____ Cell phone ( ) _____ - _____ Work phone ( ) _____ - _____

Mother's full name _____ Title: ☐ Mrs ☐ Ms ☐ Dr ☐ Other _____

Occupation _____ Email address _____

Address *(if different)* _____

Home Phone *(if different)* ( ) _____ - _____ Cell phone ( ) _____ - _____ Work phone ( ) _____ - _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address *(If different than page 1)* _____ City, State, Zip _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Email address(es) _____

Social Security # _____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

MEDICAL INSURANCE

Policy holder's full name _____

Insurance Company _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Does your child eat a well-balanced diet?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Does your child frequently breathe through his/her mouth?
- ☐ ☐ ☐ Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ ☐ ☐ Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has your child had allergies or reactions to any of the following?

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances _____

DENTAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Erupting teeth very early or very late?
- ☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Any lost or broken fillings?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ Frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Has your child been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

_____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child take antibiotic pre-medication before any dental procedures? _____

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

_____

How often does your child brush? _____ Floss? _____

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

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 y 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 payers 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; and/or ,
- 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

Privacy Consent

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment , you should review, sign and date this form.

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 in connection with your treatment, payment of your account or health care options (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____

Patient's Signature

_____

Print Name

_____

Date

- 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;
- To adivise 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 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.

Patient _____ Date _____

Insurance Co-Payment Policy

As a courtesy and convenience for our patients, this office agrees to accept insurance co-payment as a means of prearrangement for payment of the orthodontic fee. We must however, have agreement and understanding of our policy regarding this issue.

The patient or responsible party must take responsibility for confirming eligibility for orthodontic benefits. This can be done by having the responsible party call their designated representative to determine eligibility and amounts of coverage. It would be suggested that the responsible party request a written authorization from their insurance carrier. Another means of doing this would be for our office to submit a pre-treatment authorization on the patient's behalf. This takes more time since we would be waiting on return mail.

The responsible party may also choose to begin treatment before confirming eligibility for orthodontic benefits by signing the following statement.

I understand that I am responsible for the full orthodontic fee for _____ regardless of the possible insurance benefits payable. I choose to make financial arrangements using my anticipated insurance benefits for co-payment. I further understand that in the event the insurance determines that there is reduced or no benefits, then I would need to revise my current financial arrangement so that the full payment for the treatment fee will be satisfied in the estimated active treatment time frame.
Signed:_____

Insurance Information

Please complete the information below and present insurance cards to the receptionist.

Insured Party:_____ Date of Birth_____

Relationship to Pt.:_____ Social Security:_____

Employer:_____

Insurance Company_____

Claims Address: _____

Policy#_____ Group#_____Subscriber ID_____

CAMELLIA
ORTHODONTICS

Photo Release

☐ Option 1: I give my permission for Camellia Orthodontics to display my/my child's photo in the following ways:

- Bulletin Board in office
- Camellia Orthodontics Facebook/Instagram Page
- Camellia Orthodontics Website

☐ Option 2: I do not wish to have my/my child's photo displayed by Camellia Orthodontics in any way.

I understand that signing this release is optional and Camellia Orthodontics will not post my photos without my permission.

Patient's Name: _____.

Parent name (if patient is minor): _____.

Patient/Parent Signature: _____.