phillips ORTHODONTICS

Changing lives one smile at a time

Tell Us About Your Child

Today's Date: ____ /____ /____

Child's Full Name: _____ Prefers to be called: _____

Physical Address: _____ City: _____ State: _____ ZIP: _____

Mailing Address *(if different)*: _____ City: _____ State: _____ ZIP: _____

Birth Date: ____ /____ /____ Age: ____ ☐ Male ☐ Female How long at current address? _____ Family e-mail: _____

Child's General Dentist: _____ Approximate last visit date: _____ Home #: _____

School: _____ Grade: _____ Hobbies / Sports: _____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____ Do you have legal custody of this child? ☐ Yes ☐ No

Who may we thank for referring you? _____

List family members we have seen: _____

List additional brothers / sisters with ages: _____

_____

Mother's Information

Name _____ Birth date: ____ /____ /____

Address (if different): _____ How long at current address? _____

Cell #: _____ Cell provider: _____ SS#: _____ DL#: _____

Employer: _____ Job Title: _____ How long at current job? _____ Work #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Spouse's name (if not natural father): _____

Father's Information

Name _____ Birth date: ____ /____ /____

Address (if different): _____ How long at current address? _____

Cell #: _____ Cell provider: _____ SS#: _____ DL#: _____

Employer: _____ Job Title: _____ How long at current job? _____ Work #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Spouse's name (if not natural mother): _____

Third Party Information: ☐ Stepfather ☐ Stepmother ☐ Grandparent ☐ Other _____

Name _____ Birth date: ____ /____ /____

Address (if different): _____ How long at current address? _____

Cell #: _____ Cell provider: _____ Home #: _____

Employer: _____ Job Title: _____ How long at current job? _____ Work #: _____

If insurance is involved or if financially responsible, please include the following:

SS#: _____ DL#: _____

Dental Insurance Information

Primary Insurance Company Name: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth date: ____ /____ /____ ID #: _____ Employer: _____

Secondary Insurance Company Name: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth date: ____ /____ /____ ID #: _____ Employer: _____

Health History

What are your main concerns regarding the patient's smile? _____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No If so, when? _____

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No If so, please describe: _____

Please list any musical instruments that the patient plays: _____

Have 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

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

Child's Physician: _____ Phone #: _____ Last visit: _____

Please list any drugs that your child is currently taking: _____

Describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has puberty begun? ☐ Yes ☐ No Has menstruation begun (girls)? ☐ Yes ☐ No

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

Latex: ☐ Yes ☐ No Metals: ☐ Yes ☐ No Plastics: ☐ Yes ☐ No

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

☐ Yes	☐ No	Abnormal Bleeding	☐ Yes	☐ No	Handicaps / Disabilities	☐ Yes	☐ No	Hearing Impairment
☐ Yes	☐ No	ADD / ADHD	☐ Yes	☐ No	Any Hospital Stays	☐ Yes	☐ No	Heart Murmur
☐ Yes	☐ No	Any Operations	☐ Yes	☐ No	Artificial Bones / Joints / Valves	☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	HIV+ / AIDS	☐ Yes	☐ No	Cancer
☐ Yes	☐ No	Kidney / Liver Problems	☐ Yes	☐ No	Congenital Heart Defect	☐ Yes	☐ No	Lupus
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Convulsions / Epilepsy
☐ Yes	☐ No	Rheumatic / Scarlet Fever	☐ Yes	☐ No	Hemophilia			

Please discuss any medical problems your child has had: _____

_____

Has your child ever experienced any of the following?

☐ Yes	☐ No	Clenching / Grinding Teeth	☐ Yes	☐ No	Nail Biting	☐ Yes	☐ No	Thumb / Finger Sucking
☐ Yes	☐ No	Lip Sucking / Biting	☐ Yes	☐ No	Nursing Bottle Habits	☐ Yes	☐ No	Tongue Thrust
☐ Yes	☐ No	Mouth Breather	☐ Yes	☐ No	Speech Problems			

I understand that the information that I have provided is correct to the best of my knowledge, and that HIPAA guidelines will be followed regarding this information. I also understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need.

_____
Signature of Parent or Guardian Date

If this office accepts assignment of benefits for my insurance, I authorize payment directly to Daniel. S. Phillips, DMD, PC. If this office does not accept assignment of benefits of my insurance, I understand that the insurance payments will come directly to the insured member, and I will be responsible for reimbursing the office. I am ultimately responsible for any fees or deductibles that are not covered by my insurance plan.

_____
Signature of Parent or Guardian Date

This office reserves the right to verify the credit status of financially responsible parties prior to extending cr edit for treatment fees, and may use the services of a credit reporting institution.

_____
Signature of Parent or Guardian Date

The parent or guardian who accompanies the child is responsible for payment

OFFICE USE ONLY

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

Doctor's Comments: _____

_____

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ORTHODONTICS

PRIVACY NOTICE ACKNOWLEDGEMENT (HIPAA)

This is a summary of our office's privacy policy. You will see that we have posted a detailed policy statement in the reception area. We will be happy to provide you with the detailed policy statement if you wish.

Our staff is trained in preserving the privacy of your protected health information. We will only share this information as needed for the purposes of treatment, payment, and administrative operation of the office. If we need to share your protected information for other reasons (i.e. research) we will discuss this with you and ask for written consent.

As our office is small, our staff members are cross-trained and will have access to your protected information. They will utilize information only as permitted by law. Any breach of our policy will involve appropriate actions.

Should you have any questions regarding your privacy, please address your concerns to Daniel S. Phillips, DMD. If you feel a complaint is warranted, you may file one in writing with the above listed names. As noted under HIPAA regulations, there will be no retaliatory action against patients wishing to exercise their rights under these guidelines.

Patient Name(s):_____

I have received a copy of the Privacy Notice for this organization on today's date.

Signed: _____ Date: _____

By Signing below, you authorize the following people to receive information regarding your treatment and/or financial information:

Name: _____Relationship:_____

Approval Signature: _____ Date: _____

☐ Treatment ☐ Financial

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to Patient Name:_____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (please specify)_____

Signed: _____ Date: _____