YOUTH ORTHODONTIC ACQUAINTANCE CARD

(patients 18 years of age or younger)

DATE_____20_____

DATE OF BIRTH_____

PATIENT'S NAME_____NICKNAME_____AGE_____SEX_____
LAST FIRST

ADDRESS_____ZIP_____TEL (H) _____(C) _____

SCHOOL_____GRADE_____DENTIST_____

PHYSICIAN_____PATIENT'S ORAL SURGEON_____

FATHER'S NAME_____OCCUPATION_____

HOME ADDRESS IF DIFFERENT FROM ABOVE_____TEL (H) _____(C) _____

EMPLOYED BY_____BUS. TEL_____

MOTHER'S NAME_____OCCUPATION_____

HOME ADDRESS IF DIFFERENT FROM ABOVE_____TEL (H) _____(C) _____

EMPLOYED BY_____BUS. TEL_____

RESPONSIBLE PARTY_____

DO YOU HAVE DENTAL INSURANCE? _____ORTHODONTIC COVERAGE? _____

FATHER'S DENTAL INSURANCE PROGRAM_____GROUP#_____CERTIFICATE#_____

FATHER'S SS#_____FATHER'S DATE OF BIRTH_____

MOTHER'S DENTAL INSURANCE PROGRAM_____GROUP#_____CERTIFICATE#_____

MOTHER'S SS#_____MOTHER'S DATE OF BIRTH_____

NAME & AGES OF OTHER CHILDREN IN FAMILY_____

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MEDICAL HISTORY

	YES	NO
IS PATIENT IN GOOD HEALTH? _____	Y	N
DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____	Y	N
IS PATIENT UNDER A PHYSICAN'S CARE NOW? _____	Y	N

IF YES, REASON_____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS_____

ARE YOU AWARE OF ANY OF THE FOLLOWING MEDICAL CONDITIONS? PLEASE CHECK:

HEART CONDITION ☐ RHEUMATIC FEVER ☐ DIABETES ☐ EPILEPSY ☐

HEPATITIS/LIVER PROBLEM ☐ SURGERY OF HEAD/ NECK ☐ EXCESSIVE BLEEDING ☐ GROWTH PROBLEM ☐

DRUG REACTIONS ☐ ALLERGIES ☐ TUBERCULOSIS ☐ TONSILS OR ADENOID REMOVAL ☐

DOES PATIENT HAVE TENDENCY TO: COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐ SINUS PROBLEMS ☐

HEIGHT_____WEIGHT_____ FATHER'S HEIGHT_____MOTHER'S HEIGHT_____

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DENTAL HISTORY

	YES	NO
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH or TEETH? _____	Y	N
HAS THE PATIENT EVER SUCKED A THUMB, FINGER OR PACIFIER? _____UNTIL WHAT AGE? _____	Y	N
DOES THE PATIENT HAVE ANY SPEECH CONCERNS? _____	Y	N
IS THE PATIENT A MOUTH BREATHER? _____WHILE AWAKE? _____WHILE ASLEEP? _____	Y	N
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____	Y	N
HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____	Y	N
HAS EITHER PARENT OR OTHER CHILDREN HAD ORTHODONTIC TREATMENT? _____	Y	N
DOES PATIENT VOMIT, GAG OR FAINT EASILY? _____	Y	N
ANY PAIN IN OR NEAR THE EARS? RIGHT_____ LEFT_____	Y	N

LAST VISIT TO A DENTIST? _____

WHAT WOULD YOU WISH TO GAIN BY ORTHODONTIC TREATMENT? _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

ORTHODONTIC ACQUAINTANCE CARD – page 2 of 2

AUTHORIZATION AND OFFICE POLICY

*I authorize and request my insurance company to pay my insurance benefits directly to MIDCOAST ORTHODONTICS.

*I understand that my dental insurance carrier may pay less than the actual bill for services, and I am responsible for the portion of the bill which the insurance company does not cover.

*We want you to get the maximum benefit from your dental insurance. We will file the appropriate initial claims throughout your treatment. If you are unsatisfied with the benefits provided by your insurance company, it is your responsibility to file all claim resubmissions and mediate with your insurance provider.

*I agree to be responsible for payments of all services rendered on my behalf or my dependents. Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons.

*Any account balance sixty (60) days past due will be assessed a finance charge of 1.5% per month.

*I understand it may be necessary to schedule some orthodontic appointments during school or work hours.

SIGN HERE_____DATE_____

Signature of Patient or Responsible Party if minor

NOTICE OF PRIVACY PRACTICES – HIPPA

Disclosure of Health Information

We may use and disclose health information about you/your child for treatment, payment, and coordination of healthcare with other providers. We may disclose your/your child's information to another healthcare provider. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to anyone besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your/your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information. If you request copies we will charge you for each page for staff time to locate and copy the information, and postage if you want the copies mailed.

Restriction: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of information.

Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means.

Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about your access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the U.S. Department of Health and Human Services. If you have any further questions about our privacy practices, please ask us for clarification.

Signature_____ Date_____