



PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____

Patient's name _____
First Middle Last

Address _____
Street City Zip

Nickname _____ Birthdate _____ Social Security # _____

School _____ Sports/Hobbies _____

Parent or guardian name _____

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

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status M S D W
First Middle Last

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Cell phone _____ Home phone _____ Work phone _____

Email _____ Social Security # _____

Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Relationship to Patient _____ Birthdate _____

Insurance Company _____ Group No. _____ Member ID/SS # _____

Insurance Phone No. _____ Do you have dual coverage? Yes No If Yes:

Insured's Name _____ Relationship to Patient _____ Birthdate _____

Insurance Company _____ Group No. _____ Member ID/SS # _____

Insurance Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please check Yes or No (If Yes, please fill in details)

- | | | |
|------------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking any medication? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to any medication? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of a major illness? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any operations? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been involved in a serious accident? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever smoked or chewed tobacco? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have seen a physician in the last 12 months? Why? _____ |
| Female Patients only: | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has menstruation started? _____ |

Please check any of the medical conditions below that you have had or currently have.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Herpes | <input type="checkbox"/> LATEX allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Asthma or Hayfever | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently in any dental pain? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced any unfavorable reaction to dentistry? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have your wisdom teeth been removed? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever lost or chipped any teeth? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have there been any injuries to face, mouth, or teeth? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is any part of your mouth sensitive to temperature? Where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is any part of your mouth sensitive to pressure? Where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed when you brush? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any type of thumb or tongue habit? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a mouth breather? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever seen an orthodontist? If yes, who and when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | What is your attitude toward receiving orthodontic treatment? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has anyone in your family received orthodontic treatment? _____ |
| | | How did they feel about the result? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware of your jaw clicking or popping? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware of clenching your teeth during the day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told that you grind your teeth? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have "tension" headaches? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced chronic ringing in your ears? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware that appointments will be during work hours? _____ |

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Marlo Miller to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Use of electronic communication (fax, voicemail, texting) to transmit treatment, appointment changes, any related information and/or other results.

I hereby authorize all providers, including Physicians and Physician Assistants to furnish information to medical insurance carriers concerning myself or my dependents illnesses and treatments and hereby assign to the doctor all payments for medical/dental services rendered. I understand that I am responsible for providing any and all insurance information at the time of services, and that I will be responsible for any amount not covered by insurance.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the office at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient (Parent) (Self) (Guardian)

Signature _____ Date_____

Photo Image Release

I, the undersigned, authorize Marlo Miller Orthodontics and her employees to take photos, videos, or digital records of me to use in all medias.

I further consent my name may be revealed therein or by descriptive text or commentary.

I release all rights to exhibit this work in prints and electronic form publicly.

Patient Name _____

Relationship to Patient (Parent) (Self) (Guardian)

Signature _____ Date_____



Marlo A. Miller, D.D.S., M.S.
ORTHODONTICS
Board Certified

Pediatric Sleep Questionnaire

Patient Name: _____ Date: _____

Dr. Miller would like you to complete this form as accurately and honestly as possible. In our practice we are very interested in our patients' overall health. Orthodontic treatment can be an important part of managing the health problems caused by sleep and breathing disorders.

- ___ While Sleeping, does your child snore more than half the time?
- ___ While Sleeping, does your child always snore?
- ___ While Sleeping, does your child snore loudly?
- ___ While Sleeping, does your child have "heavy" or loud breathing?
- ___ While Sleeping, does your child have trouble breathing or struggle to breath?
- ___ Have you ever seen your child stop breathing during the night?
- ___ Does your child occasionally wet the bed, sleepwalk, or have night terrors (circle any)?
- ___ Does your child tend to breath through the mouth during the day?
- ___ Does your child have a dry mouth when waking up in the morning?
- ___ Does your child wake up unrefreshed in the morning?
- ___ Does your child wake up with headaches in the morning?
- ___ Does your child have a problem with sleepiness during the day?
- ___ Has a teacher or supervisor commented your child looks sleepy during the day?
- ___ Did your child stop growing at a normal rate at any time since birth?
- ___ Is your child overweight?
- ___ This child often does not seem to listen when spoken to directly
- ___ This child often has difficulty organizing task and activities
- ___ This child often is easily distracted by extraneous
- ___ This child often fidgets with hands or feet or squirms in seat
- ___ This child is often "on the go" or often acts as if "driven by a motor"
- ___ This child often interrupts or intrudes on others (butts into conversations or games)

Total Score = _____