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	
☐	☐	Are you taking any medication? _____
☐	☐	Are you allergic to any medication? _____
☐	☐	Do you have a history of a major illness? _____
☐	☐	Have you had any operations? _____
☐	☐	Have you ever been involved in a serious accident? _____
☐	☐	Have you ever smoked or chewed tobacco? _____
☐	☐	Have seen a physician in the last 12 months? Why? _____
		Female Patients only:
☐	☐	Are you pregnant? _____
☐	☐	Has menstruation started? _____

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

☐ Abnormal bleeding/Hemophilia	☐ Diabetes	☐ Hepatitis/Liver problems	☐ Pneumonia
☐ Anemia	☐ Dizziness	☐ Herpes	☐ LATEX allergy
☐ Arthritis	☐ Epilepsy	☐ High Blood Pressure	☐ Radiation/Chemotherapy
☐ Asthma or Hayfever	☐ Gastrointestinal Disorders	☐ HIV / Aids	☐ Rheumatic Fever
☐ Bone Disorders	☐ Heart Problems	☐ Kidney problems	☐ Tuberculosis
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Nervous Disorders	☐ 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	
☐	☐	Are you presently in any dental pain? _____
☐	☐	Have you ever experienced any unfavorable reaction to dentistry? _____
☐	☐	Have your wisdom teeth been removed? _____
☐	☐	Have you ever lost or chipped any teeth? _____
☐	☐	Have there been any injuries to face, mouth, or teeth? _____
☐	☐	Is any part of your mouth sensitive to temperature? Where? _____
☐	☐	Is any part of your mouth sensitive to pressure? Where? _____
☐	☐	Do your gums bleed when you brush? _____
☐	☐	Do you have any type of thumb or tongue habit? _____
☐	☐	Are you a mouth breather? _____
☐	☐	Have you ever seen an orthodontist? If yes, who and when? _____
☐	☐	What is your attitude toward receiving orthodontic treatment? _____
☐	☐	Has anyone in your family received orthodontic treatment? _____
		How did they feel about the result? _____
☐	☐	Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
☐	☐	Are you aware of your jaw clicking or popping? _____
☐	☐	Are you aware of clenching your teeth during the day? _____
☐	☐	Have you ever been told that you grind your teeth? _____
☐	☐	Do you have “tension” headaches?_____
☐	☐	Have you ever experienced chronic ringing in your ears? _____
☐	☐	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_____

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 = _____

Patient's Name_____ Birthday_____ Today's Date_____

Previous clip or release of tongue? Yes / No (Date)_____

Has your child experienced any of the following issues? Please check or elaborate as needed.

Speech

_____Frustration with Communication

_____Difficult to understand by parents

_____Difficult to understand by outsiders

_____% Percent of time you understand your child

_____Difficulty speaking fast

_____Difficulty getting words out (groping for words)

_____Trouble with sounds (which?)

_____Speech delay (when?)

_____Stuttering

_____Speech harder to understand in long sentences

_____Speech therapy (how long)

_____Mumbling or speaking softly

_____"Baby Talk"

Feeding

_____Frustration when eating

_____Difficulty transitioning to solid foods

_____Slow eater (doesn't finish meals)

_____Grazes on food throughout the day

_____Packs food in cheeks like a chipmunk

_____Picky eater/ textures (which?)

_____Choking or gagging on food

_____Spits out food

_____Won't try new foods

_____Other:

Nursing or Bottle-Feeding Issues as a Baby

_____Painful nursing or shallow latch

_____Poor Weight gain

_____Reflux or spitting up

_____Unable to hold pacifier

_____Milk dribbling out of mouth

_____Poor Supply

_____Nipple shield required for nursing

_____Clicking or smacking noise when eating

_____Other:

Other Related Issues

_____Neck or shoulder pain or tension

_____Headaches or migraines

_____Strong gag reflex

_____Tonsils or adenoids removed previously

_____Ear tubes previously/recurrent ear infections

_____Reflux (medicated or not)

_____Constipation

_____Enlarged tonsils and/or adenoids

_____Frequent sinus issues/upper respiratory infections

_____Eczema/Allergies

_____Diagnosed with ADD/ADHD

_____Diagnosed with Autism