PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. Obtaining payment from third payers (e.g. my insurance company)
3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date ____________________________

Print Patient Name: _____________________________________________________________

Relationship to Patient: __________________________________________________________

Print Name of Parent/Guardian: __________________________________________________

Signature of Parent/Guardian: ____________________________________________________

Patient Consent Form
We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we’ll be glad to help you. We look forward to working with you in creating your beautiful smile!

Patient Information

Name: ____________________________________________ Date of Birth: _____/_____/_____ Age:____
Nickname: ___________________ Male: _____ Female: _____ Social Security: _______-_______-_______
Address: ________________________________ City: __________________ State: _____ Zip: __________
Home Telephone: ______-_______-_______ Whom May We Thank For Your Referral: _______________
Patient’s Dentist: ___________________________ Last Check-up/Cleaning: ____/____/____

Responsible Party Information

Mother/Guardian Name: ______________________________________ Date of Birth: _____/_____/_____ Social Security: ______-_______-_______ Employer: __________________________________________
Address: _________________________________ City: _________________ State: _____ Zip: __________
Home Telephone: ______-_______-_______ Work: _____-______-______ Cell: ______-_______-______

Father/Guardian Name: _______________________________________ Date of Birth: ____/_____/_____
Social Security: ______-_______-_______ Employer: __________________________________________
Address: _________________________________ City: _________________ State: _____ Zip: __________
Home Telephone: ______-_______-_______ Work: _____-______-______ Cell: ______-_______-______

Primary Insurance Coverage

Primary Insured Name: _____________________________________ Date of Birth: _____/_____/_____ Relationship to Patient: ___________________________ Social Security: ______-______-______ Employer: _________________________________ Address: __________________________________
Name of Insurance: ___________________________________ Group Number: _____________________
Address: _________________________________________________ Telephone: _____-______-______

Secondary Insurance Coverage

Secondary Insured Name: ____________________________________Date of Birth: _____/_____/_____ Relationship of Patient: ___________________________ Social Security: ______-_______-_______ Employer: ________________________________ Address: __________________________________
Name of Insurance: ___________________________________ Group Number: _____________________
Address: _________________________________________________ Telephone: ______-______-______
Dental History

Reason for Dental/Orthodontic Examination: ________________________________________________

Has Patient Had Previous Dental/Orthodontic Treatment/Consultation?

Y  N Speech Problems Y  N Thumb Sucking Y  N Have Tonsils Been Removed
Y  N Lip Biting Y  N Finger Biting Y  N Food Collects Between Teeth
Y  N Bleeding Gums Y  N Grinding Teeth Y  N Clicking/Popping of the Jaw

Medical History

Physician’s Name: _____________________________________________ Telephone: ______-____-_____ 
Address: _____________________________ City: __________________ State: ______ Zip: ___________

Date of last physical exam: ____/____/______ Results: _______________________________________

Is patient under care of physician now Y  N If yes, why ____________________________________

Has patient ever been hospitalized Y  N If yes, why ____________________________________

Has patient ever had surgery Y  N If yes, why ____________________________________

(Women) Are you pregnant Y  N Nursing Y  N Taking birth control pills Y  N

Has Patient reached Puberty Y  N Girl started menstruation Y  N Boy has voice changed Y  N

Has the Patient had any of the following:

Y  N A.I.D.S/H.I.V Y  N Cerebral Palsy Y  N Hay Fever Y  N Mental Retardation
Y  N Anemia Y  N Cleft Lip /Palate Y  N Hearing Problems Y  N Rheumatic Fever
Y  N Asthma Y  N Convulsions Y  N Heart Problems Y  N Sinus Problems
Y  N Bladder Problems Y  N Developmental Y  N Hepatitis Y  N Thyroid Disease
Y  N Blood Transfusion Y  N Diabetes Y  N Jaundice Y  N Tuberculosis
Y  N Bruise Easily Y  N Epilepsy Y  N Kidney Disease Y  N Premature
Y  N Cancer Y  N Fainting Y  N Liver Disease Y  N Phen Phen

Other: ________________________________________________________________________________

Is Patient taking any Medication? _______ If yes, list names and purpose: __________________________

Are You Allergic to or had a reaction to any of the following? Please Circle

Aspirin Barbiturates Sedatives Metal Local Anesthetics None Known
Amoxicillin Sleeping Pills Sulfa Drugs Latex Any Others: ______________________

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my/my child’s medical status. I authorize the dental/orthodontic staff to perform the necessary dental/orthodontic services for my/my child. I certify that the patient is covered by insurance with: _______________________. I assign directly to Smiles 4 Kids, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that responsibility for payment for dental/orthodontic services provided in the office for me/my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize Smiles 4 Kids, to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any changes in my/my child’s insurance coverage.

Signature: _____________________________________________ Date: _____/_____/______
Your “Smile” Questionnaire

Your Name__________________________ Date____________________

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all responses):

- Too small or short? No Yes
- Too large or long? No Yes
- Crooked or crowded? No Yes
- Misshaped (uneven/pointed)? No Yes
- Off Color? No Yes

Do you feel your front teeth stick out too much (“Buck Teeth)?
- No Yes

Are there spaces between your teeth that you do not like?
- No Yes

Is there too much or too little gum tissue showing when you smile?
- No Yes

Has there been previous orthodontic treatment (including braces or other appliances)?
- No Yes

If so, when and by whom?

________________________________________________________________________

Is there a specific time of the day or week when you must be seen?

________________________________________________________________________

Are there other dental issues not listed above that you would like to discuss or have treated?
- No Yes (explain)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature__________________________________________ Relationship________