MeadowsFamilyDentistry

pediatric • orthodontic • adult care

Smiles for Life

Orthodontic Child Registration

Todays Date: _____

Patient's Full Name: _____ Patient D.O.B: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Patient lives with: Mom Dad Both Other: _____

School Name & Grade: _____

Sex: M F Height: _____ Weight: _____ Eye Color: _____ Hair Color_____

Patient Adopted? Yes No Parents Are: Married Separated Divorced Deceased Patient Looks Like: Mom Dad

Father's Email: _____ Mother's Email: _____

Father's Name: _____ Cell Phone: _____ SSN: _____ DOB: _____

Place of Employment: _____ How Long: _____ Occupation: _____

Mother's Name: _____ Cell Phone: _____ SSN: _____ DOB: _____

Place of Employment: _____ How Long: _____ Occupation: _____

Do you Have Dental Insurance? Yes No Insurance Company Name: _____ Phone: _____

Name of Insurance Subscriber: _____ Person(s)Responsible for Account: _____

Member ID (may be SSN): _____ Policy/Group #: _____

General Health: Excellent Good Fair Poor **Is Patient Taking Medication**? Yes No

Name of Meds & for what Purpose? _____

_____

Has patient Ever Been Treated For?

___ Heart Disease/Problems
___ Heart Murmur - Require Pre-Med? Y / N
___ Rheumatic Fever
___ Abnormal Blood Pressure
___ Ulcers
___ Lung Disease
___ Diabetes
___Hepatitis
___ Tonsils/Adenoids

___ Epilepsy
___ Trauma to Face/Head
___ Anemia
___ Jaundice
___ Asthma/Hay Fever
___ Sinus Trouble
___ Cough
___ Hormone Problems
___ Vision Problems
___ Bone Fractures

___ Bleeding Problems
___ Learning Disabilities (ADD/ADHD)
___ Hearing Problems
___ Speech Problems
___ Kidney Problems
___ Chiropractic Problems
___ Arthritis
___ Congenital Problems (Cleft Palate, Lip)
___Cancer
__ Joint Replacement – Require Pre-Med? Y/N

Patient is Allergic to: _____

Have Tonsils/Adenoids been removed? Yes No If yes, When? _____

Has Patient reached puberty? **Girls** – menstruation started? Yes No **Boys** – Voice changed? Yes No

Are there any additional health factors that should be brought to our attention? _____

_____

Does the patient have a history of:

Finger or Thumb Sucking: Yes No **Suck Tongue or other objects**: Yes No

Suck lower lip between upper/lower teeth: Yes No **Nail biting**: Yes No

Did the patients teeth erupt: Slow On time Late

Have there been any injuries to the teeth or jaw? Yes No When? _____

Have any teeth been lost early due to accidents? Yes No When? _____

Have any teeth been extracted with the intent of making space for other teeth to erupt? Yes No

If Yes, under whose care? Dr. _____ When? _____

Have any space maintainers been worn? Yes No

If Yes, under whose care? Dr. _____ When? _____

Have "Braces" (Orthodontic Appliances) ever been worn? Yes No

If Yes, under whose care? Dr. _____ When? _____

Has anyone in the family been treated or examined by an Orthodontist before? Yes No

If Yes, Who and under whose care? Dr. _____ When? _____

Previous Dental experiences: Good Fair Poor **Date of Last Dental Cleaning**: _____

(It is important to have had a dental examination & cleaning within 6 months prior to starting orthodontic treatment.)

***Name of Current Dental Provider: _____**

Were X-rays taken? Yes No **Is all dental work complete?** Yes No

If not, what is remaining? _____

Is Patient a mouth breather? Yes No **Any jaw issues?** Clicking popping pain

Does the patient play any musical instruments with the mouth? Yes No **If yes, what instrument? _____**

What are your feelings about possibly having orthodontic treatment? _____

_____

What is the reason for seeking an orthodontic evaluation? _____

_____

How did you hear about our office? (Who may we thank for referring you) _____

Parent or Legal Guardian Signature: _____

(A parent or legally responsible adult must accompany patient under 18 years of age at initial visit)

We take great pride in providing the BEST care available!! *4/2021*

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HIPAA Disclosure and Release of Information

I, _____, hereby authorize Meadows Family Dentistry, LLC (hereafter collectively referred to as the "Practice") to use and disclose the entire medical record concerning _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have received and reviewed a copy of the NOPP, been given an opportunity to ask questions about it, understand it and do here by agree to its terms. A copy of this signed, dated Consent shall be effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

_____ _____ _____

Patient Name | Signature of patient or parent/guardian | Date

Consent for Communication and/or Disclosure

I request the following alternative or limitations relating to communication directed to me by my healthcare provider or employee of Meadows Family Dentistry, LLC. I understand that this HIPAA consent applies to ALL providers of Meadows Family Dentistry. It is my responsibility to notify Meadows Family Dentistry of any changes.

Do we have permission to:

Send appointment reminders via (please check the following): TEXT ☐ EMAIL ☐ BOTH ☐

Leave the following information on your home/cell voicemail?

Appointment Information ___Yes___No

Billing Information ___Yes ___No

Medical Information ___Yes ___No

I give my permission to share the following information with the person(s) listed below:

Name: _____ Relationship: _____

Appointment: ___Yes ___No Billing: ___Yes ___No Medical: ___Yes ___No

Name: _____ Relationship: _____

Appointment: ___Yes ___No Billing: ___Yes ___No Medical :___Yes ___No

_____ _____ _____

Patient Name | Signature of patient or parent/guardian | Date