Members American Association of Orthodontists

Welcome

CHILDREN AND ADOLESCENTS

PATIENT INFORMATION - Please Print (Confidential) Date _____

_____ _____

First Middle Last Nickname

Age _____ Date of Birth ____/____/____ Gender ___M ___F Home Phone ( ) _____

Full Home Address _____

Patient's School _____ Grade _____

Person to Contact in Case of Emergency _____ Relationship_____ Phone ( )_____
(Not Living at Same Address)

Name of Family Dentist _____ Date of Last Dental Check-up_____

Who can we thank for referring patient to our office? _____

Musical Instruments/Hobbies/Sports_____

Has patient had any Previous Orthodontic Treatment or Orthodontic Consultations? ❑ Yes ❑ No

If so, when and where? _____

What are your main concerns about the patients teeth? _____

FAMILY INFORMATION

Father's Name _____ Full Address_____

Father's Employer_____Occupation_____H Phone ( ) _____W Phone ( ) _____

Cell Phone ( ) _____Social Security Number_____

Mother's Name _____Full Address_____

Mother's Employer_____Occupation_____H Phone ( ) _____W Phone ( ) _____

Cell Phone ( ) _____Social Security Number_____

Have any of your family members been previously treated at our offices? ❑ Yes ❑ No Names_____

Email: _____

Patient Medical History

Physician _____ Phone ( ) _____ Date of Last Exam_____

	YES	NO
1. Is patient under medical treatment now?	❑	❑
2. Has patient ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain: _____		
3. Is patient taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) is patient taking? _____		
4. Has patient ever taken Phen-Fen/Redux?	❑	❑
5. Does patient use tobacco?	❑	❑
6. Does patient use controlled substances?	❑	❑
7. Is patient wearing contact lenses?	❑	❑

8. Does patient have or have they had any of the following?

	YES	NO
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Rheumatic Fever	❑	❑
Swollen Ankles	❑	❑
Fainting/Seizures	❑	❑
Asthma	❑	❑
Low Blood Pressure	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney Disease	❑	❑
Aids or HIV Infections	❑	❑
Thyroid Problem	❑	❑
Bleeding Disorders	❑	❑
Nervous Disorders	❑	❑
Heart Disease	❑	❑
Cardiac Pacemaker	❑	❑
Heart Murmur	❑	❑
Angina	❑	❑
Frequently Tired	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Arthritis	❑	❑
Joint Replacement or Implant	❑	❑
Hepatitis/Jaundice	❑	❑
Sexually Transmitted Disease	❑	❑
Stomach Troubles/Ulcers	❑	❑
Autoimmune Disease	❑	❑
Artificial Prosthesis	❑	❑
Chest Pains	❑	❑
Easily Irritated	❑	❑
Stroke	❑	❑
Hay Fever/Allergies	❑	❑
Tuberculosis	❑	❑
Radiation Therapy	❑	❑
Glaucoma	❑	❑
Recent Weight Loss	❑	❑
Liver Disease	❑	❑
Heart Trouble	❑	❑
Respiratory Problems	❑	❑
Mitral Valve Problem	❑	❑

Other Medical Problems:

1. _____
2. _____

9. Is patient allergic to or have had any reactions to the following?

	YES	NO
Local anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list)	❑	❑

10. Women Only

	YES	NO
a. Is patient pregnant or thinking she may be pregnant?	❑	❑
b. Is patient taking oral contraceptives?	❑	❑

✶ **DOES THE PATIENT REQUIRE ANTIBIOTICS FOR DENTAL TREATMENT? ❑ YES ❑ NO**

Patient Dental History

	YES	NO
1. Do patients gum bleed while brushing or flossing?	❑	❑
2. Are teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Does patient feel pain in any teeth?	❑	❑
5. Has patient any sores or lumps in or near mouth?	❑	❑
6. Has patient had any head, neck or jaw injuries?	❑	❑
7. Has patient ever experienced any of the following problems in his/her jaw?		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑

	YES	NO
8. Does patient have frequent headaches?	❑	❑
9. Does patient clench or grind teeth?	❑	❑
10. Does patient bit lips or cheeks frequently?	❑	❑
11. Has patient ever had difficult extractions?	❑	❑
12. Has patient ever had prolong bleeding?	❑	❑
13. Has patient ever had any orthodontic treatment?	❑	❑
14. Has patient ever received oral hygiene instructions regarding care of teeth/gums?	❑	❑
15. Does patient like their smile?	❑	❑

16. What is your chief orthodontic (dental) concern(s)?

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to patient's health. I authorize Nahas & Donahue Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Nahas & Donahue Orthodontics any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of the patient.

X_____

Signature of Parent or Guardian Relationship to Patient Date

Doctors Comments_____

_____

_____

_____ Signature_____ Date_____

NAHAS AND DONAHUE ORTHODONTICS

GEORGE H. NAHAS, DDS
THOMAS J. DONAHUE, DMD
ORTHODONTIC SPECIALISTS

WELCOME TO OUR OFFICE!

Please take a moment to complete the following so that we can better serve you!

ORTHODONTIC INSURANCE INFORMATION FORM

PRIMARY ORTHODONTIC INSURANCE

Patient Name _____ Patient Birthdate _____
Insurance Holder Name _____
Relationship to Patient _____
Insured Social Security # _____ Insured Holder Birthdate _____
Full Address _____
Employer _____
Home Phone # _____ Business Phone # _____
Insur Co Name _____ Insur Co Phone #_____
Insur Co Full Address _____
Subscriber # _____ Group #_____

ADDITIONAL ORTHODONTIC INSURANCE

Patient Name _____ Patient Birthdate _____
Insurance Holder Name _____
Relationship to Patient _____
Insured Social Security # _____ Insurance Holder Birthdate _____
Full Address _____
Employer _____
Home Phone # _____ Business Phone # _____
Insur Co Name _____ Insur Co Phone # _____ _____
Insur Company Full Address _____
Subscriber # _____ Group # _____

AUTHORIZATION

I authorize my insurance company to pay *Nahas and Donahue Orthodontics* all orthodontic benefits otherwise payable to me for services rendered.
I authorize the use of the undersigned signature for all insurance submissions. I authorize *Nahas and Donahue Orthodontics* to release any information necessary to process and secure the payment of benefits. I understand that I am financially responsible for any charges not paid by insurance, including those charges that may be incurred by a change in, or loss of, insurance benefits.

SIGNATURE _____ DATE _____

RELEASE AUTHORIZING USE OF PERSONAL LIKENESS

I, _____(patient full name), consent to the use of my personal image and likeness including, but not limited to images or video representing and/or depicting the treatment provided to me by Drs. Nahas & Donahue, and the effect thereof, for any lawful use. Drs. Nahas & Donahue deem appropriate, including for treatment, advertising his/her its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational purposes.

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by Drs. Nahas & Donahue during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising promotional or education materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Drs. Nahas & Donahue. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Drs. Nahas & Donahue will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that Drs. Nahas & Donahue cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Drs. Nahas & Donahue may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and any other relevant medical conditions, in describing the treatment rendered to me as depicted in any image or video of me.

I understand that Drs. Nahas & Donahue may not and have not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness.

I have read the foregoing in it's entirely and understand its terms.

_____ _____

Patient / Guardian Signature **Date**

_____ _____

Print Guardian Name (if patient is a minor) **Guardian Relationship to Patient**

_____ _____

Provider Signature **Date**

NAHAS & DONAHUE ORTHODONTICS
GEORGE H. NAHAS, DDS & THOMAS J. DONAHUE, DMD

Notice of Privacy Practices Acknowledgement

By signing this form, you will consent to our use and disclosure of your protected health information (PHI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in treatment directly or indirectly
- To obtain payment for services provided to you through third party payers
- To conduct normal healthcare operations such as quality assessments, etc.

I have received/been offered a copy of the above-named office's Notice of Privacy Practices (NOPP) containing a detailed description of the uses and disclosures of my PHI.

We reserve the right to change our privacy practices as described in our NOPP. If we change our privacy practices, we will issue a revised NOPP, which will contact the changes. Those changes may apply to any of your PHI that we maintain.

I understand that I have the right to revoke this consent at any time by giving us written notice of your revocation submitted to your office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities, and health car operations.

_____

Patient – Print Name

_____

Name of Parent/Guardian & Relationship to Patient **Date**

OFFICE USE ONLY

_____ Individual Refused to Sign

_____

Signature of Doctor Date