NEW BRAUNFELS
BRACES

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent or guardian's name_____

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

Confidential Responsible Party Information

Name_____ Marital Status_____
Last First Middle

Residence_____ Own Rent
Street City State Zip

Mailing Address_____
Street City State Zip

Cell Phone_____ Home Phone_____ Work Phone_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ E-mail address: _____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Social Security #_____ Birthdate_____ Cell Phone_____

Insurance Information

Policy Holder's Name_____

Birthdate_____ Soc.Sec. #_____

Insurance Company_____ Employer:_____ ID No._____

Do you have dual coverage? Yes ✎ No ✎ If yes:

Policy Holder's Name_____

Birthdate_____ Soc. Sec. #_____

Insurance Company_____ ID No._____ Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

Signature (Parent's signature if minor)_____

Orthodontic History

PLEASE ANSWER ALL QUESTIONS FOR THE PATIENT IF HE/SHE IS A MINOR AND FOR YOURSELF IF YOU ARE THE PATIENT.

Describe in your own words what you understand the orthodontic problem to be: _____

_____

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

Is this your first orthodontic evaluation? _____

Has anyone in the family received orthodontic treatment by another orthodontist? _____

How did they feel about the result? _____

Names of any family members we have treated: _____

What is your attitude toward receiving orthodontic treatment? _____

Dental History

Dentist: _____ Date of last visit: _____

Address: _____ Phone: _____

Please circle Yes or No (if Yes, please fill in details)

Yes No Have you ever had a bad experience in a dental office? Describe: _____

_____

Yes No Have you ever chipped or lost any teeth? _____

Yes No Have there been any injuries to your face, mouth,or teeth? _____

Yes No Is any part of your mouth sensitive to temperature or pressure? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have your tonsils and/ or adenoids been removed? At what age? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth at night? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No Have you ever been told you have TMJ problems? _____

Medical History

Physician: _____ Date of last visit: _____ Weight: _____

Address: _____ Phone: _____

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Are you allergic to any metal or latex? _____

Yes No Have you ever had a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Have you ever taken any Bisphosphonates? *Actonel/Riserdronate, Aredia/Pamidronate, Didronel Etidronate, Fosamax/Alendronate, Skelid/Tilndronate, Zoledronic Acid*

Circle any of the medical conditions you may have.

Abnormal bleeding/ Hemophilia	Diabetes	Hepatitis/ Liver problems	Pneumonia	
Anemia	Dizziness	Herpes		Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy	
Asthma or Hayfever	Gastrointestinal Diorders	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 we should be aware of? _____

_____

X Signature (Parent's signature if minor) _____ Date: _____

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form. Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent. Thank you for your cooperation. Please let us know if you have any questions.

_____ _____

Signature Date

PATIENT PHOTO RELEASE

Patient Name _____

The above named patient (or parents/legal guardian) of San Antonio Orthodontics, consent to authorized the use and reproduction of photographs and audiovisual material whenever print or electronic format. I understand that these pictures, name, and only may appear in such publicity material for promotional and educational purposes only.

☐ I accept to having my photo released

☐ I decline to have my photo released

_____

Signature