



WELCOME TO THE ORTHODONTIST



Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____ M F
LAST FIRST MI

Birthdate: ____ / ____ / ____ Age: ____ SS #: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home # (_____) _____

Child's Home Address: _____

CITY STATE ZIP

E-mail Address: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

CITY STATE ZIP

Previous Address: _____

CITY STATE ZIP

Hm # (_____) _____ DL #: _____

Employer: _____

Wk # (_____) _____ SS #: _____

Who is responsible for making appointments?

Name: _____ Wk # (_____) _____

Cell # (_____) _____ Hm # (_____) _____

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we thank for referring you? _____

List other family members seen by us _____

General Dentist: _____

Date of last cleaning / visit: _____

Parent's Marital Status: Single Partnered Divorced
 Married Separated Widowed

3 Parental Information

Mother Stepmother Guardian

Name: _____ Birthdate ____ / ____ / ____

Wk # (_____) _____ Hm # (_____) _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____ DL #: _____

Father Stepfather Guardian

Name: _____ Birthdate ____ / ____ / ____

Wk # (_____) _____ Hm # (_____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

6

What would you like orthodontics to accomplish?

Has your child ever taken Phen-Fen? Y N
(Redux or Pondimin) If yes, when? _____

Has your child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played: _____

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Y N

Does your child brush his / her teeth daily? Y N

Does your child floss his / her teeth daily? Y N

Child's Physician: _____

Phone # (____) _____ Date of last visit: _____

Is your child under the care of a physician? Y N

Has puberty begun? Y N

Girls - Has menstruation begun? Y N

Please describe your child's current physical health: Good Fair Poor

Please list all drugs that your child is currently taking:

Please list all drugs/things that your child is allergic to:

Latex Y N Metals/Nickel Y N Plastics Y N

7

Has your child ever had any of the following medical problems?

- | | |
|--------------------------------|-------------------------------|
| Y N Abnormal Bleeding | Y N Convulsions / Epilepsy |
| Y N ADD / ADHD | Y N Diabetes |
| Y N Allergies to Any Drugs | Y N Handicaps / Disabilities |
| Y N Allergic to Latex / Metals | Y N Hearing Impairment |
| Y N Allergic to Plastic | Y N Heart Murmur |
| Y N Any Hospital Stays | Y N Hemophilia |
| Y N Any Operations | Y N Hepatitis |
| Y N Artificial Bones / Joints | Y N HIV+ / AIDS |
| Y N Artificial Valves | Y N Kidney / Liver Problems |
| Y N Asthma | Y N Lupus |
| Y N Cancer | Y N Rheumatic / Scarlet Fever |
| Y N Congenital Heart Defect | Y N Tuberculosis (TB) |

Please discuss any medical problems that your child has had:

8

Has your child ever experienced any of the following?

- | | |
|--------------------------------|-----------------------------|
| Y N Clenching / Grinding Teeth | Y N Nursing / Bottle Habits |
| Y N Lip Sucking / Biting | Y N Speech Problems |
| Y N Mouth Breather | Y N Thumb / Finger Sucking |
| Y N Nail Biting | Y N Tongue Thrust |

Neighbor or Relative not living with you

Name _____ Ph # (____) _____

Address _____

CITY STATE ZIP

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services that my child may need.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____ **Initials:** _____ **Date:** _____

Welcome!

From all of us at your orthodontist office
We would like to get to know you better so we can be friends.
Won't you please tell us about yourself?

Name: _____ What do your friends call you? _____

My pet is a:



Its name is:

What school do you go to?



What grade are you in?

What's your favorite TV show?



What's your favorite subject?

What is your favorite food?



What sports do you like?



What sports do you play?

Who is your hero and why?



My favorite things to do after school and on the weekends are:



PATIENT PHOTOGRAPH AND TESTIMONIAL AUTHORIZATION FORM

I hereby give my consent for **Shawn L. Miller, DMD, Inc.** to take photographs, slides and/or videotape of (*Print full name of patient*) _____ face, jaw, and teeth. I understand that some of these images may be seen and used by other dental professionals, and these images will become part of the patient record.

If I have provided a written testimonial about my experience with **Shawn L. Miller, DMD, Inc.**, the testimonial may be used in whole or in part as indicated below.

Please circle "do" or "do not" for each statement, and initial.

- I do do not consent to the use of these images in professional articles and presentations. _____
- I do do not consent to the use of these images within the dental practice to be seen only by individuals who walk into the practice. _____
- I do do not consent to the use of these images to promote the dental practice through various media, including but not limited to print advertising, brochures, and the practice web site. _____

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise, from **Shawn L. Miller, DMD, Inc.** I hereby release and discharge **Shawn L. Miller, DMD, Inc.** from any and all claims and demands arising out of or in connection with the use of my name, photograph, personal testimonial, or other information provided by me, including any and all claims for libel and invasion of privacy.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

Print Patient's or Legal Guardian's/Representative's Name

Patient's or Legal Guardian's/Representative's Signature

Date

Shawn L. Miller, DMD, Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Shawn L. Miller

Telephone: 714-639-1061 Fax: 714-639-3184

E-mail: info@MillerBraces.com

Address: 1110 East Chapman Avenue, Suite 205, Orange, CA 92866

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____