Reopelle ORTHODONTICS

Medical and Dental History

Case ______________
Date ______________

Patient Information

Last Name ________________ First Name _______________ Middle Initial ___ ☐ Female ☐ Male
Preferred Name ________________________ SSN ____________________ DOB _______________
Address _______________________________ City ________________ State ____ Zip Code _______
Age ____ School ____________________________ Grade ____ Adopted? ☐ Yes ☐ No
Siblings _________________________ Hobbies/Interests _____________________________________
Emergency Contact ______________ Relationship to Patient _______________ Phone ____________

Guardian 1
Relationship: ☐ Father ☐ Mother ☐ ________
Name ________________________________
Address ______________________________
City _________ State ___ Zip Code ________
Phone ________________________________
Email ________________________________
DOB ____________ SSN _________________
Employer _____________________________
Occupation ___________________________

Guardian 2
Relationship: ☐ Father ☐ Mother ☐ _________
Name _________________________________
Address _______________________________
City __________ State ____ Zip Code _______
Phone _________________________________
Email _________________________________
DOB ____________ SSN __________________
Employer ______________________________
Occupation ____________________________

Parents' Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered

Financial Responsibility

Who is responsible for this account and relationship to patient? ______________________________

Primary Dental Insurance

Primary Policyholder's Full Name ________________________ DOB ___________ SSN ______________
Address and Phone (if not above) ____
Relationship to Patient ____
Employer _______________________ Address ____
Insurance Company ______________ Group# __________________ ID# ______________________
Insurance Company's Phone ________________________ Orthodontic Coverage: ☐ Yes ☐ No

I authorize release of any information regarding my child's treatment to my dental insurance company.

Parent/Guardian Signature ______________________________________ Date _________________

Medical History

☐ Yes ☐ No Is your child in good health? Child's Physician __________________________________
Last Seen _______________ Phone ____
☐ Yes ☐ No Any medical specialist(s) being seen now? Reason ______________________________
☐ Yes ☐ No Has patient reached puberty? (Girls: Monthly Cycle; Boys: Voice Change)
Height _______ Weight _________

□ Yes □ No Has your child ever had a health problem? ______________________________

□ Yes □ No Has your child ever been hospitalized? Reasons and dates ______________________

____

□ Yes □ No Medicine or drug allergies? ______________________ □ Acrylic □ Nickel □ Latex

□ Yes □ No Is your child taking any medications? Provide medication, dose and reason ________

____

□ Yes □ No Antibiotic premedication before dental visits?

Please check the box if your child has been treated for any of the following:

□ Abnormal Bleeding	□ Autism	□ GI/GERD	□ Rheumatic Fever
□ ADD/ADHD	□ Cancer/Tumors	□ Hearing/Speech	□ Sensory/Behavior
□ Anemia	□ Diabetes	□ Heart Murmur/Disease	□ Seizure(s)
□ Any Operations	□ Endocrine/Growth	□ HIV/AIDS	□ Tuberculosis (TB)
□ Asthma/Breathing	□ Frequent Infections	□ Kidney/Liver	□ Other __________

Explain any checked boxes ____

____

____

Dental History

Dentist ______________________ Address ______________________________

Last Seen ____________________ Reason _______________________________

□ Yes □ No Any dental specialist(s) being seen now? Reason ______________________

How often does your child: Brush teeth? ________ Floss? ________

Please check the box if your child has been treated for any of the following:

□ Extra or missing teeth	□ Speech concerns/therapy	□ Jaw joint clicking or locking
□ Chipped or injured teeth	□ Mouth breathing or snoring	□ Jaw joint pain
□ Gum disease	□ Tongue thrust	
□ Habits (thumb sucking, etc.)	□ Grinding or clenching	

Explain any checked boxes ____

____

General Information

What concerns you or your child about his/her teeth? ______________________________

How does your child feel about orthodontic treatment? ______________________________

Does your child play a musical instrument? ______________________________

Who may we thank for referring you to our office? ______________________________

Previous orthodontic consultation? □ Yes □ No; Previous orthodontic treatment? □ Yes □ No

Have any other family members been treated in our office? Name(s) ______________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature ______________________________ Date ______________

Consent for Disclosure of Protected Health Information (HIPAA)

SECTION A: Patient/Parent/Legal Guardian Giving Consent

Patient Name: ____ Date of Birth: ______________________

SECTION B: 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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain, and we will provide you with a copy of the revised Notice of Privacy Practices upon your request.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting it from us.

Reopelle Orthodontics
2114 Colonial Avenue, SW
Roanoke, VA 24015
(540)344-2758

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. 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 will 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 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 or my child's protected health information as described in the "Notice of Privacy Practices."

Signature: ____ **Date:** ______________________

Relationship to Patient: ____

Other person(s) to whom you give permission to discuss health information or bring child to routine care appointments:

Name: ____ Relationship to patient: ______________________

Name: ____ Relationship to patient: ______________________

Name: ____ Relationship to patient: ______________________