COA
Creative Orthodontic Associates

CHILD PATIENT INFORMATION

Patient Information

Last Name _____ First _____ MI _____
Nickname _____ Sex _____ Age _____ Birthdate _____
Home Address _____
City _____ State _____ Zip code _____
Telephone # _____

Mother's Information

Mother's Name _____ Birthdate _____ Social Security # _____
Address (if different from above) _____
Occupation _____ Name of Employer _____
Business Address _____
City _____ State _____ Zip code _____
Home Telephone # _____ Cellular Telephone # _____
Business Telephone # _____ E-Mail Address _____

Father's Information

Father's Name _____ Birthdate _____ Social Security # _____
Address (if different from above) _____
Occupation _____ Name of Employer _____
Business Address _____
City _____ State _____ Zip code _____
Home Telephone # _____ Cellular Telephone # _____
Business Telephone # _____ E-Mail Address _____

Which is the best telephone number to reach you? _____
What is the best way to confirm your appointments? ◯ Telephone ◯ Text ◯ E-Mail

Name of Doctor who referred you to our office _____
If not a Doctor, where did you hear about our office? _____
Family Dentist _____ Date of last visit _____ Physician _____
What is the reason for coming to our office? _____
Has your child had any previous orthodontic evaluation or treatment? ◯ Yes ◯ No
Has your child had any trauma to jaws or teeth? _____
Does your child have clicking or pain in the jaw joints; facial pain, clenching, tooth grinding, etc? ◯ Yes ◯ No
If so, for how long? Please explain fully: _____
Are you interested in cosmetic braces, clear braces or invisible braces? _____
Is there any additional information that would be helpful in evaluating and treating your child? ◯ Yes ◯ No
_____

Sibling information

Name _____ Birthdate _____ Age _____ ○ M ○ F

Name _____ Birthdate _____ Age _____ ○ M ○ F

Name _____ Birthdate _____ Age _____ ○ M ○ F

In case of emergency please contact _____

Telephone # _____ Relation to patient _____

Dental Insurance Information

Primary Carrier _____

Company name _____

Address _____

City _____ State _____ Zip Code _____

Telephone # _____

Name of the insured _____

Social Security # of insured _____

Birthdate of Insured _____

Relationship of patient to insured _____

Policy # _____ Group # _____

Effective Date of Policy _____

Secondary Carrier _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Date: _____

SIGNATURE (PATIENT OR PARENTS If MINOR)

Company name _____

Address _____

City _____ State _____ Zip Code _____

Telephone # _____

Name of the insured _____

Social Security # of insured _____

Birthdate of Insured _____

Relationship of patient to insured _____

Policy # _____ Group # _____

Effective Date of Policy _____

I hereby authorize payment directly to the below named Dentist of the group insurance benefits otherwise payable to me.

Date: _____

SIGNATURE (INSURED PERSON)

A PHOTOCOPY OF MY SIGNATURE SHALL SERVE AS AN ORIGINAL FOR INSURANCE PURPOSES (“SIGNATURE ON FILE”)

THE INFORMATION ON THE FRONT AND BACK OF THIS PAGE IS CORRECT.

SIGNATURE

Date: _____

Signature of Parent/Guardian

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.c., individually identifiable information, such as names, dates, phone/fax numbers, e-mail addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., The American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by the other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person to direct your questions to this person at our office address. Thank you

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Date: _____

Patient

American Dental Association
www.ada.org

Patient's Name _____ (LAST) _____ (FIRST) _____ (INITIAL)

Nickname _____ Date of Birth _____

Parent's/Guardian's Name _____ Relationship to Patient _____

Address: _____ (PO OR MAILING ADDRESS) City _____ State _____ Zip: _____

Phone _____ (HOME) _____ (WORK) Sex: ◯ M ◯ F

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ◯ Yes ◯ No

1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Chronic Sinusitis	☐ HIV +/AIDS	☐ Rheumatic fever
☐ Arthritis	☐ Diabetes	☐ Immunizations	☐ Seizures
☐ Asthma	☐ Ear Aches	☐ Kidney	☐ Sickle cell
☐ Bladder	☐ Epilepsy	☐ Latex allergy	☐ Thyroid
☐ Bleeding disorders	☐ Fainting	☐ Liver	☐ Tobacco/Drug Use
☐ Bones/Joints	☐ Growth Problems	☐ Measles	☐ Tuberculosis
☐ Cancer	☐ Hearing	☐ Mononucleosis	☐ Venereal Disease
☐ Cerebral Palsy	☐ Heart	☐ Mumps	☐ Othe
☐ Chicken Pox	☐ Hepatitis	☐ Pregnancy (teens)	_____

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? 1. ◯ Yes ◯ No

If yes, please list: _____

2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____

2. ◯ Yes ◯ No

3.Is the child allergic to anything else, such as certain foods? If yes, please explain: _____

3. ◯ Yes ◯ No

4.How would you describe the child's eating habits? _____

5.Has the child ever had a serious illness? If yes, when: _____

Please describe: _____

5. ◯ Yes ◯ No

6.Has the child ever been hospitalized? . 6. ◯ Yes ◯ No

7. Does the child have a history of any other illnesses? If yes, please list: _____ 7. ◯ Yes ◯ No

8.Has the child ever received a general anesthetic? 8. ◯ Yes ◯ No

9.Does the child have any inherited problems? 9. ◯ Yes ◯ No

10.Does the child have any speech difficulties? 10. ◯ Yes ◯ No

11.Has the child ever had a blood transfusion? 11. ◯ Yes ◯ No

12.Is the child physically, mentally, or emotionally impaired? 12. ◯ Yes ◯ No

13.Does the child experience excessive bleeding when cut? 13. ◯ Yes ◯ No

14.Is the child currently being treated for any illnesses? 14. ◯ Yes ◯ No

15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____

15. ◯ Yes ◯ No

16.Has the child had any problem with dental treatment in the past? 16. ◯ Yes ◯ No

17.Has the child ever had dental radiographs (x-rays) exposed? 17. ◯ Yes ◯ No

18.Has the child ever suffered any injuries to the mouth, head or teeth? 18. ◯ Yes ◯ No

19.Has the child had any problems with the eruption or shedding of teeth? 19. ◯ Yes ◯ No

20.Has the child had any orthodontic treatment? 20. ◯ Yes ◯ No

21. What type of water does your child drink? ◯ City water ◯ Well water ◯ Bottled water ◯ Filtered water

22.Does the child take fluoride supplements? 22. ◯ Yes ◯ No

23.Is fluoride toothpaste used? 23. ◯ Yes ◯ No

24. How many times are the child's teeth brushed per day? _____

When are the teeth brushed? _____

24. ◯ Yes ◯ No

26. At what age did the child stop bottle feeding? Age _____

Breast feeding? Age _____

27. Does child participate in active recreational activities? 27. ◯ Yes ◯ No

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date: _____

For completion by dentist

Comments _____