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Family Information

Date ___________

Patient's Name ______________________ Preferred Name ______________________
Birthdate ______________________ Age ________ Sex ☐ Male ☐ Female
School ______________________ Grade ________ Email ______________________
Mailing Address ______________________ How Long ______________________
City, State, Zip ______________________ Home Phone ______________________
Mother's Name ______________________ Cell Phone ______________________
Employer ______________________ How Long _____ Occupation ______________________
Father's Name ______________________ Cell Phone ______________________
Employer ______________________ How Long _____ Occupation ______________________

Do you have dental insurance with orthodontic benefits? ☐ Yes ☐ No ☐ Unsure

General Appraisal

Chief Concern (Reason for consultation) ______________________

Does patient's problem resemble ☐ Father ☐ Mother ☐ Sibling(s) ☐ Adopted

Other children in family	Age	Sex	Had Ortho treatment	Reason for Treatment
1-				
2-				
3-				
4-				

Sports/Hobbies ______________________ Musical instruments ___________ Hours/day ___________

Are you aware that the success of orthodontic treatment depends on cooperation? ☐ Yes ☐ No
What is the patient's attitude towards treatment? ☐ Excited ☐ Nervous but accepting ☐ Apprehensive ☐ Indifferent
How well will the patient follow instructions? ☐ Very well ☐ Good with reminders ☐ Poorly ☐ Unsure

Medical History

Physician/Pediatrician ______________________ Phone ___________ Last exam ___________
Is he/she currently under treatment? ☐ No ☐ Yes ______________________
Is he/she currently taking medication? ☐ No ☐ Yes ______________________
Has he/she ever been hospitalized? ☐ No ☐ Yes ______________________
Has he/she ever had an operation? ☐ No ☐ Yes ______________________
Is he/she allergic to anything? ☐ No ☐ Yes ______________________

Girls- Has menstruation begun ☐ No ☐ Yes Is the patient pregnant ☐ Yes ☐ No
Boys- Has his voice changed ☐ No ☐ Yes

Does patient have a history of: ☐ None

☐ Anemia ☐ Bone Disorder ☐ Epilepsy/Seizures ☐ Kidney Disorders
☐ Asthma ☐ Cancer/Radiation/Chemotherapy ☐ Fainting or Dizziness ☐ Liver Disorders
☐ Bleeding Disorder ☐ Diabetes ☐ Heart Disorders ☐ Psychological Symptoms
☐ Birth Defects ☐ Endocrine/Thyroid Disorders ☐ Immune Disorders ☐ Rheumatic Fever

Please describe ______________________

Dental History

Dentist ______________________ Last Visit ___________ Reason ___________
How often does the patient brush? ___________ How often does the patient floss? ___________

Does patient have a history of: ☐ None

☐ Nail Biting ☐ Bleeding Gums ☐ Mouth Breathing
☐ Lip Biting/Licking ☐ Grinding/Clenching ☐ Thumb/Finger sucking until age ___________
☐ *Injuries to mouth or face* ______________________

Is there any other information you think we should know? ______________________
Whom may we thank for your referral? ______________________

HIPAA CONSENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of their health information to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. Thank you for your cooperation and please let us know if you have any questions.

Print Name: _______________________ Signature_______________________ Date: ____________

PRIVACY AUTHORIZATION

This Authorization is required by the privacy regulations recently promulgated by the United States Department of Health and Human Services.
Your protected health information including individually identifiable information, such as names, dates, phone/fax numbers, email addresses, demographic data, photographs, x-rays, and study models may be used or disclosed for the purpose(s) of: lectures/presentations, publications, research, practice marketing.

This information will be disclosed by the following people: Victor J.R. Grazina DDS, PC

The information will be disclosed to the following people/entities: Those listed above.

You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on.

The information used or disclosed per this Authorization may be subject to re-disclosure by the recipient(s), and thus, no longer protected by the privacy rules.

Print Name: _______________________ Signature_______________________ Date: ____________