



**PATIENT INFORMATION - MINOR**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Male/Female**

**Hobbies/Interests:** \_\_\_\_\_

**Attends school at:** \_\_\_\_\_

**Number of siblings:** \_\_\_\_\_

**Sibling's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Male/Female**

**Sibling's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Male/Female**

**Sibling's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Male/Female**

**Sibling's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Male/Female**

**PARENT INFORMATION**

**Mother's Name:** \_\_\_\_\_ **Married** **Divorced** **Single** **Widowed**

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Email address:** \_\_\_\_\_

**Mother's Employer:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Married** **Divorced** **Single** **Widowed**

**Address(if different):** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Email address:** \_\_\_\_\_

**Father's Employer:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**General Dentist:** \_\_\_\_\_ **Date last seen:** \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

**Policy Holder's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ID #/Social Security #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Dental Insurance Plan Name & Address:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**REFERRAL INFORMATION**

**Name of person/office referring you to our practice:** \_\_\_\_\_

**Emergency contact (not living with you) :** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Relationship to child:** \_\_\_\_\_



## Dental and Health History

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Gender M F

Dental Orthodontic History	Yes	No	Additional Information
Thumb/Finger sucking			
Tongue thrust			
Clenching/Grinding teeth			
Mouth breathing habit, snoring or difficulty in breathing			
Chipped or otherwise injured primary (baby) or permanent teeth			
Difficulty in chewing or jaw opening			
Had periodontal (gum) treatment			
Teeth sensitive to hot or cold			
Speech problems			
Supernumerary (extra) or congenitally missing teeth			
Had prior orthodontic examination or treatment			
Bleeding gums, bad taste or mouth odor			
Periodontal "gum" problems			
Any pain or soreness in the muscles of the face or around the ears			
Aware of any loose, broken or missing restorations (fillings)			
Using any forms of fluoride			
Suffered injuries to your face, mouth, teeth or chin			

Medical History	Yes	No
Abnormal Bleeding		
Hypertension		
ADD or ADHD		
AIDS/HIV		
Any operation		
Artificial Joints/Valves		
Asthma		
Autism		
Cancer		
Congenital Heart Disorder		
Convulsions		
Diabetes		
Epilepsy		
Handicaps/Disabilities		
Heart Murmur		
Hemophilia		
Hepatitis		
Kidney Problems		
Liver Problems		
Mitral Valve Prolapse		
Prosthetics		
Rheumatic Fever		
Scarlet Fever		
Sickle Cell Disease		
Tuberculosis (TB)		

First                      Middle                      Last

**Medical History**  
 Primary Physician \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Last Visit \_\_\_\_\_

Current Physical Health is: Good \_\_\_\_ Fair \_\_\_\_  
 Poor \_\_\_\_ Explain \_\_\_\_\_

List medications currently taking \_\_\_\_\_

Is pre-med required for dental visits (please circle)      No      Yes  
 Explain \_\_\_\_\_

Allergies to medications: No \_\_\_\_ Yes \_\_\_\_ Explain \_\_\_\_\_  
 Other allergies No \_\_\_\_ Yes \_\_\_\_  
 Latex \_\_\_\_ Metals \_\_\_\_ Nickel \_\_\_\_ Plastic \_\_\_\_ other \_\_\_\_\_

### Authorization

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is my responsibility to inform Newtown Orthodontics of changes in my child's or my own medical status. I authorize the orthodontic staff to perform the necessary dental and/or orthodontic services on my child (if applicable) or myself as needed.

\_\_\_\_\_  
 Patient signature (legal guardian if minor)                      Date

**HIPAA OMNIBUS RULE**  
**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

**Guy Coby D.M.D**  
**Heather Albert D.M.D**  
**Newtown Orthodontics LLC**  
**46 Blacksmith Rd, "Suite Tooth"**  
**Newtown, PA 18940**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_  
Please **print** patient name

\_\_\_\_\_  
Parent/Guardian Please **sign**

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Description of Authority

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only     Proper Sir Name     Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- |  |   |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> <b>None of the above</b> (opt out) |
| <input type="checkbox"/> Email         |   |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- |  |       |
|--|-------|
| It was emergency treatment               | _____ |
| I could not communicate with the patient | _____ |
| The patient refused to sign              | _____ |
| The patient was unable to sign because   | _____ |
| Other (please describe)                  | _____ |

\_\_\_\_\_  
Signature of Privacy Officer

Consent for the Orthodontic Patient

Fortunately, in orthodontics the complications are infrequent, and when they do occur they are usually of minor consequence. Nevertheless, they should be considered when making the decision to undergo orthodontic treatment.

Cavities and permanent markings, such as white lines or spots on the teeth, can occur if patients do not brush frequently and properly, or if they eat hard, sugary or sticky foods. Regular visits to the family dentist are essential in monitoring the health of teeth. Children, adults, and teenagers may require these visits every to 6 months. Adults should have a periodontal evaluation by their family dentist or periodontist before beginning orthodontic treatment.

A tooth that has been previously injured by a blow or has a large filling may require root canal therapy when it is moved with orthodontic appliances. In some cases, the roots of the teeth may become blunted or shortened during treatment. Usually, this is of no consequence, but on rare occasions it may require curtailing treatment, to avoid loss of a tooth.

Teeth have a tendency to change position after orthodontic treatment. This is usually only a minor change, and faithful wearing of retainers can reduce this tendency. The lower front teeth are a common site for these changes, and you should expect some changes in this area. Occasionally a person who has had a normal growth of the jaw may not continue to do so. If growth becomes uneven, the relationship of the jaws may change. This may require additional treatment or in some cases, surgery. Growth disharmony is a biological process beyond the orthodontist's control. All forms of medical and dental treatment including orthodontics have some risks and limitations.

Lack of signs and symptoms of a temporomandibular joint (TMJ) problem does not indicate conclusively that a problem doesn't exist. A TMJ problem may occur during orthodontic treatment and may or may not be related to the treatment. Such a problem may require additional studies or treatment of referral for these problems. Orthodontic treatment can improve dental causes of TMJ pain, but not in all cases.

There have been few reports of injury to the eyes in patients wearing headgear. These patients were either removing the headgear incorrectly or engaging in strenuous horseplay or competitive activities while wearing the appliance. Patients are advised not to wear their headgear during these times.

Due to the wide variation in the size and shape of teeth achievement of the most ideal result (for example, complete closure of excessive space) may require restorative dental treatment. The most common types of treatment are cosmetic bonding, crown and bridge restorative dental care and/or periodontal therapy. You are encouraged to ask questions regarding dental and medical care adjunctive to orthodontic treatment of those doctors who provide these services.

General medical problems can affect orthodontic treatment. You should keep your orthodontist informed of any changes in you medical health. You should inform your orthodontist of any unusual symptoms or broken or loose appliances, as soon as they are noted. The total time for treatment can be longer than estimated. Lack of bone growth, poor cooperation, broken appliances and missed appointments are important factors which can lengthen treatment and affect the quality of the result. I also understand that should any of the above conditions threaten the health of this patient, this practice may terminate treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that s/he is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections from insurance companies and will credit any such collections to the patient's account. However, this orthodontic office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If it becomes necessary to refer an outstanding account balance for collection there will be an additional 33% charge. The responsible party agrees that they are responsible for all attorney's fees and costs incurred in the collection of this debt.

The under signer hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make through diagnosis of the patient's needs. I grant permission to you or your assignee to telephone me at home or my work to discuss matters related to my treatment. I give my authorization to transfer any records or radiographs to another provider for treatment of my child. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

\_\_\_\_\_  
Signature of patient, or parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Administrator

\_\_\_\_\_  
Date

