Patient Information

PATIENT NAME | PATIENT'S D.O.B | AGE

NICKNAME | MALE | FEMALE | SS #

STREET ADDRESS, APT NO. | CITY | STATE | ZIP

PHONE# | CELL# | WORK# | EXT

Responsible Party Information

NAME | D.O.B. | RELATIONSHIP TO PATIENT

STREET ADDRESS, APT NO. | CITY | STATE | ZIP

PHONE# | CELL# | WORK# | EXT.

SS # | DRIVER'S LICENSE# & STATE ISSUED

E-MAIL ADDRESS

MARITAL STATUS: O SINGLE O MARRIED O DIVORCED O WIDOWED

DO YOU HAVE LEGAL CUSTODY? O YES O NO

IF NO, WHO IS THE LEGAL GUARDIAN?

Insurance Information

NAME OF POLICY HOLDER | POLICY HOLDER'S D.O.B.

POLICY HOLDER'S SS # | EMPLOYER | WORK#

NAME OF INSURANCE | GROUP# | ID#

INSURANCE ADDRESS | CITY | STATE | ZIP

INSURANCE PHONE# | RELATIONSHIP TO PATIENT

Secondary Insurance

NAME OF POLICY HOLDER | POLICY HOLDER'S D.O.B.

POLICY HOLDER'S SS # | EMPLOYER | WORK#

NAME OF INSURANCE | GROUP# | ID#

INSURANCE ADDRESS | CITY | STATE | ZIP

INSURANCE PHONE# | RELATIONSHIP TO PATIENT

Medicaid Insurance

ELIGIBLE? O YES O NO

IF YES, MEDICAID#

Emergency Contact Information

NAME | PHONE# | CELL#

RELATION

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices

Notice to Patient or Responsible Party if Patient is a Minor: We are required to provide you with a copy of our notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

PRINT YOUR NAME

SIGNATURE | DATE

Patient Information

Medical Information: Please check yes or no

A. Does the patient currently have or has the patient ever had any of the following:

	YES	NO
Heart Disease		
Respiratory Disease		
Blood Disease		
Liver Disease		
Thyroid Disease		
Kidney Disease		
Stomach Disease		
Venereal Disease		
Intestinal Disease		
Bone Disease		
Hearing Problems		
Nervous/Emotional Problems		
ADHD		
High or Low Blood Pressure		
Endocrine Problems		
Problems with Wounds Healing		
Night Sweats		
Weight Loss		
Anorexia		

	YES	NO
Fever		
Persistent cough		
Bloody sputum		
tumors or cancer		
rheumatic/yellow/scarlet fever		
aiDS/hiv		
rheumatism or arthritis		
Fainting or dizziness		
measles/mumps/chicken pox		
Fever blisters		
heart murmur		
mononucleosis		
hepatitis		
Polio		
Diabetes		
anemia		
hemophilia		
emphysema		

	YES	NO
epilepsy		
asthma or hay fever		
tuberculosis		
Broken bones		
Prolonged bleeding		
yellow jaundice		
radiation therapy		
chemical therapy		
Blood transfusions		
Sinus problems		
Severe/frequent headaches		
Difficulty breathing		
Drug/alcohol abuse		
any stays in the hospital? When/why?		
Other		

B. Is the patient allergic to:

	YES	NO
Aspirin		
Codeine		
Latex		
Erythromycin		
Penicillin		
Dental anesthetics		
Tetracycline		
Other List:		

Is the patient:

	YES	NO
Under the care of a doctor? What for? Doctor's name:		
taking medication? list:		
in ❑ good ❑ fair ❑ poor health?		

	YES	NO
Normal height/weight?		
Past puberty?		
taking birth control pills?		
Pregnant? Week No. _____		
currently smoking?		
addicted to drugs/alcohol?		
currently taking, or has the patient ever taken, medications known as bisphosphonates?		
Seen by a physician routinely? Physician's name:		

C. Dental History – Has the patient:

	YES	NO
Seen his/her general dentist in the last six months?		
had any pain, clicking, or discomfort in or near the ears?		
Been informed of missing or extra permanent teeth?		
had mouth, face, or teeth injured by a fall or accident?		
Been told of any 'gum' problems?		
had a physician or dentist prescribe antibiotics before a dental exam?		
had tonsils or adenoids removed?		
Been examined by an orthodontist before? if so, when and by whom?		
have other members of the family had orthodontic treatment? if yes, were they happy with the results?		
had frequent headaches?		
Does the patient mind wearing braces?		

Has the patient ever had the following habits:

	YES	NO
Cheek, Tongue or Lip Chewing		
Sucks thumb/fingers		
Mouth breathing		
Teeth clenching		
Teeth grinding		
Tongue thrusting		
Speech problems		

Reviewed By

Date

Whom may we thank for referring you?
❑ general Dentist ❑ Friend ❑ Relative ❑ Patient
Their name:_____

If not referred, how did you hear about us?
❑ Web Search ❑ TV ❑ Billboard ❑ event ❑ Print ad ❑ yellow Pages
Other:_____

The information that i have given is correct, to the best of my knowledge. i understand that it is my responsibility to inform this office of any changes in my/my child's medical or dental status.

I request that the doctors and staff of Dolphin Braces transfer manually and/or electronically all information related to payment for and treatment of my/my child's orthodontic case to other dentists, physicians, insurance companies, Medicaid programs, and support companies (i.e. custom appliance labs, computerized study model companies). Such reports may include, but are not limited to, medical, dental, and orthodontic care and treatment; illness or injury; dental and medical history; consultation; prescriptions; x-rays; photographs; models; and all copies of financial payment, dental, and medical records.

I also authorize the dental staff to perform the necessary dental services that I/my child may need during treatment.

Signature of Patient/Legal Guardian _____ Date _____

Privacy/Courtesy Policy

(Recommended **by** HIPPA)

Family Members in Treatment Areas

Because parents play such an important role in the success of their children's orthodontic case, we encourage a parent to accompany his or her child to the treatment area and comply with the following guideline.

Many orthodontic offices allow only the patient in clinic treatment area. Our office has provided seating at each clinic operatory for a **maximum of one adult family member** to accompany the patient.

In order to comply with the privacy laws (HIPPA) and still allow adult family members in our open clinic area, our Office Privacy/ Courtesy Policy requires family members to:

- Be escorted by an assistant into and out of the clinic treatment area and exam rooms. Wandering through the halls and into other treatment areas cannot be permitted.
- Remain seated on the bench provided at the back of your child's clinic operatory. Please DO NOT stand next to the dental chair unless requested by the assistant or orthodontist.
- Leave infants and young children at home or with an adult in the waiting room. We love youngsters but they often interfere without staff providing necessary treatment/ consultations and should not be brought into treatment areas.
- Schedule a consultation with our orthodontist in a private exam room if extensive questions require discussions. Only brief explanations should take place in the clinic.

In order to comply with the TEXAS law, a **parent or legal guardian must be present** in the office when treatment is being provided to children less than 15 years of age.

In order to keep the noise level and distractions in our clinic at a minimum, we request that you turn off your phone, when entering treatment areas.

We also request that no food or drinks be brought into the office and/or clinic. Please dispose of all food and drinks in the trash receptacle at the front door. We hope that you will comply with our guidelines, so that we may continue to allow a family member to accompany each patient into the clinic areas.

_____	_____	_____
Patient Signature	**Parent/Guardian Signature**	**Date**

Modern Smiles, LLC dba SmileLife
3201 Cherry Ridge., Ste A-101
San Antonio, TX 78230
www.smilelifebraces.com
Privacy Officer Phone: 210-616-2030
Privacy Officer Email: admin@hcr-audit.com

Notice of Privacy Practices Acknowledgement

I acknowledge receiving the practice's "Notice of Privacy Practices" dated 11/1/2019.

Name	Signature	Date