WELCOME

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name _____ (Last) _____ (First) _____ (Middle) Sex

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Birthdate _____ (MM-DD-YYYY) E-mail _____ Social Security# _____ (999-99-9999)

Home Phone _____ (999-999-9999) General Dentist _____ Last Visited _____

Who may we thank for referring you to our office _____

Parents Information

Father

Name _____ (Last) _____ (First) _____ (Middle) Marital Status

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Birthdate _____ (MM-DD-YYYY) E-mail _____ Social Security# _____ (999-99-9999)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) ext. _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____

Mother

Name _____ (Last) _____ (First) _____ (Middle) Marital Status

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Birthdate _____ (MM-DD-YYYY) E-mail _____ Social Security# _____ (999-99-9999)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) ext. _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____

Insurance Information

Policy Owner's Name _____ Policy Owner's Employer _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Do You have Dual Coverage

General Information

School _____

Hobbies

Brothers/Sisters (include ages)

Medical History

Medical Physician? _____ Phone _____ Last Visit _____

Is the child currently under the care of a physician? Yes No If Yes, explain _____

Has puberty begun? Yes No Has menstruation (period) begun? Yes No N/A

What are the main concerns that you would like orthodontics to accomplish? _____

Has the patient ever been evaluated for orthodontic treatment? Yes No

Has the patient tonsils or adenoids been removed? Yes No

Has the patient ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever had an injury to : (select all that apply) Teeth Mouth Chin

Does/Has the patient ever had any of the following habits?	Lip Sucking/Biting	Nail biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrusting	Thumb/ Finger Sucking

Does the patient have speech problems? Yes No If Yes, explain _____

Is the child allergic to any of the following?

Aspirin
Codeine
Tetracycline
Any Metals/Plastics
Erythromycin
Penicillin
Latex

Other Allergies/Sensitivites:

_____

List all drugs the Patient is currently taking

List any serious medical condition(s) treated

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form _____ Date _____

Mint Orthodontics

Peter An Truong, DDS, MS

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we always have and always will continue to respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another dental or medical health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your condition.
- We may have to disclose your health information or billing records to another party if they are responsible for the payment of your services.
- We may need to use your dental care information within our practice for implementation of office policy and procedures.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign your consent form. We reserve the right to change our privacy practices as described in that notice. If we make changes to our privacy practices, we will notify you in writing of any changes made.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place restrictions on the use or disclosure of your information, please let us know in writing. We are not required to agree to your restrictions; however if we do agree with your restrictions, the restrictions are binding on us.

Your Right To Revoke Your Authorization

You may revoke your consent to us at any time; however your revocation must be in writing. We will not be able to honor your revocation request if we have already released your information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to content any of your claims.

By submitting this form I acknowledge that I have read and understand this notice.