



Patient ID: \_\_\_\_\_

**CONFIDENTIAL MEDICAL/DENTAL HISTORY  
FOR PATIENTS UNDER 18**

North Office: 4935 Templeton Gap Road, Colorado Springs, CO 80923  
South Office: 1539 S 8<sup>th</sup> Street, Ste 200, Colorado Springs, CO 80905

Tel: 719-266-6224  
Tel: 719-227-7645

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[www.smilesforcolorado.com](http://www.smilesforcolorado.com)

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Prefers to be Called: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Other: \_\_\_\_\_ Email: \_\_\_\_\_

School Name: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Other Family Members treated at this office? \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address (if different from patient's): \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Single  Widowed  Divorced  Married Spouse's Name: \_\_\_\_\_

\_\_\_\_\_

Father's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address (if different from patient's): \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Single  Widowed  Divorced  Married Spouse's Name: \_\_\_\_\_

\_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

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

Date of Birth: \_\_\_\_\_

Social Sec. # \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Address: \_\_\_\_\_

Phone # on Ins. Card: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

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

Date of Birth: \_\_\_\_\_

Social Sec. # \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Address: \_\_\_\_\_

Phone # on Ins. Card: \_\_\_\_\_

## MEDICAL INFORMATION

Your answers are for office records only and are confidential. A thorough medical and dental history is essential to a complete orthodontic evaluation.

1. Has your child ever had any of the following? Please check those that apply:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> HIV/AIDS          | <input type="checkbox"/> Diabetes or low blood sugar  | <input type="checkbox"/> Jaundice                       | <input type="checkbox"/> Rheumatism       |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Kidney Disease                 | <input type="checkbox"/> Sinus Problems   |
| _____                                      | <input type="checkbox"/> Earaches                     | <input type="checkbox"/> Liver Disease                  | <input type="checkbox"/> Stomach Problems |
| _____                                      | <input type="checkbox"/> Emotional Problems           | <input type="checkbox"/> Mental Disorders               | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Epilepsy                     | <input type="checkbox"/> Mitral Valve Prolapse          | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Excessive Bleeding           | <input type="checkbox"/> Nervous Disorders              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting/Dizziness           | <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> Tumors           |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> <b>Pregnancy</b>               | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Birth defect      | <input type="checkbox"/> Hay Fever                    | Due Date: _____   | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Head Injuries                | <input type="checkbox"/> Radiation Treatment            | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Brain Injury      | <input type="checkbox"/> Heart Murmur, Heart Defects  | <input type="checkbox"/> Removal of Adenoids or Tonsils | _____                                     |
| <input type="checkbox"/> Bone Disorder     | <input type="checkbox"/> Hepatitis, or liver problems | <input type="checkbox"/> Respiratory Problems           |   |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High or Low Blood Pressure   | <input type="checkbox"/> Rheumatic Fever                |   |

2. Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: \_\_\_\_\_

3. Has your child ever taken Bisphosphonate medication (e.g. Fosamax, Actonel, Boniva, Skelid or Didronel for bone disorders)?

Yes No If yes, what medication and length of time on the medication: \_\_\_\_\_

4. Adolescent females: Has menstruation begun? Yes No If Yes, when? \_\_\_\_\_

5. Do you think that any of your child's activities affect his/her face, teeth, or jaws? How? \_\_\_\_\_

6. Is your child now under the care of a physician? Yes No

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

7. List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes:

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

8. Does your child currently have (or ever had) a substance abuse problem? Yes No

9. Does your child chew or smoke tobacco? Yes No

10. Are there any medical conditions we have not listed and you feel we should be aware of? Yes No

If yes, please explain: \_\_\_\_\_

## DENTAL HISTORY

1. What concerns you most about your child's teeth? \_\_\_\_\_

2. Does your child have any current dental problems? \_\_\_\_\_

3. Has your child ever had orthodontic treatment? Yes No

If yes, please explain: \_\_\_\_\_

4. Has anyone in your family received orthodontic treatment? Yes No

If yes, who? \_\_\_\_\_

5. Does your child feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern? \_\_\_\_\_

6. Has your child ever had an upsetting dental experience? Yes No

If yes, please describe: \_\_\_\_\_

### **Please answer the following:**

- |  |  |
|--|--|
| <input type="checkbox"/> Sensitive teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No                                     | <input type="checkbox"/> Erupting teeth very early or very late? <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| <input type="checkbox"/> Supernumerary (extra) or congenitally missing teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> History of speech problem or speech therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| <input type="checkbox"/> Tooth grinding or clenching? <input type="checkbox"/> Yes <input type="checkbox"/> No                         | <input type="checkbox"/> Any type of thumb or tongue habit? <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| <input type="checkbox"/> Gums bleed or hurt? <input type="checkbox"/> Yes <input type="checkbox"/> No                                  | <input type="checkbox"/> Mouth breathing habit or snoring at night? <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| <input type="checkbox"/> Presently in any dental pain? <input type="checkbox"/> Yes <input type="checkbox"/> No                        | <input type="checkbox"/> Clicking or popping in your child's jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| <input type="checkbox"/> Lost or chipped any teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No                           | <input type="checkbox"/> Difficulty opening or closing mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| <input type="checkbox"/> Any loose teeth or changes in your child bite? <input type="checkbox"/> Yes <input type="checkbox"/> No       | <input type="checkbox"/> Ever been treated for "TMJ" or "TMD" problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Any injuries to the face, mouth or teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No            | <input type="checkbox"/> Frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No                            |
| <input type="checkbox"/> Any mouth odors or bad tastes? <input type="checkbox"/> Yes <input type="checkbox"/> No                       |  |

I have read the above questions and understand them. To the best of my knowledge, all of the preceding answers and information provided are true and correct. I will not hold the orthodontist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the orthodontist of any changes in my child's medical and dental health.

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

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

**MEDICAL HISTORY UPDATES**

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

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

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

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

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

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

**CONSENT FOR SERVICES**

- ◆ I certify that the information provided is accurate and will be relied upon for granting credit and providing services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
- ◆ By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
- ◆ I authorize payment directly to the orthodontist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize

release of any information relating to any dental claim or claims.

- ◆ I hereby authorize the orthodontist or designated staff to take X-rays, study models, photographs and other diagnostic aids deemed appropriate by the orthodontist to make a thorough diagnosis.
- ◆ I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

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

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

## NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations, for example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connections with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restriction on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written consent.

**Required by Law:** We may use or disclose your health information when we are required to do so by law or national security activities.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information with limited exceptions. Requests of a patient's records must be made in writing and can take up to ten business days to process. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

**Amendment:** You have the right to request that we amend your health information.

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### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you are encouraged to make any complaints to us directly. You also may submit a written complaint to the U.S Department of Health and Human Services. We support your right to the privacy of your health information.

### PATIENT ACKNOWLEDGEMENT OF REVIEWING AND UNDERSTANDING OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

I, \_\_\_\_\_, consent to the use  
(Print Patient or Parent or Legal Guardian Name)

and disclosure of the patient's personal health information by this office for treatment, billing/payment, and healthcare operations as outlined in the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Parent or Legal Guardian Name

\_\_\_\_\_  
Date

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