PRETTYMAN ORTHODONTICS

WELCOME! Please tell us about the patient.

NEW PATIENT - CHILD

Has the patient been seen at any of our other locations? ☐ Yes ☐ No If yes, where: _____

How did you learn about our practice? Whom can we thank for referring you to us? _____

What is the main concern about the patient's smile? What would they like to change?

_____

Have other family members been treated here? ☐ Yes ☐ No If yes, list names: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Title: _____

Preferred Name/Nickname: _____

Street Address: _____ Apt/Unit#: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Gender: _____ Ethnic Origin: _____

Home Phone: _____ School: _____ Grade: _____

Email: _____

Mother's Name: _____ Date of Birth: _____

Address: _____

Employer: _____ Social Security Number: _____ - _____ - _____

Work Phone: _____ Cell Phone: _____ Email: _____

Father's Name: _____ Date of Birth: _____

Address: _____

Employer: _____ Social Security Number: _____ - _____ - _____

Work Phone: _____ Cell Phone: _____ Email: _____

In case of emergency, call: _____ Phone: _____

DENTAL HISTORY

Dentist's Name: _____

Date of last cleaning/exam: _____ Is any dental work needed? ☐ Yes ☐ No

Has the patient ever had an orthodontic consultation? ☐ Yes ☐ No

Has the patient had any injuries to the face, mouth, or teeth? ☐ Yes ☐ No

Has there been any pain/tenderness in the patient's jaw joints (TMJ/TMD)? ☐ Yes ☐ No

Has the patient been diagnosed with periodontal disease/bone loss? ☐ Yes ☐ No

Does the patient have any of the following habits? ☐ Thumb sucking ☐ Tongue thrust ☐ Grinding ☐ Clenching

MEDICAL HISTORY

Please check the box if the patient has or has had:

☐ Positive HIV test	☐ Tuberculosis	☐ Tonsillitis
☐ Joint swelling	☐ Anemia	☐ Adenoids removed
☐ Bone disorders	☐ Asthma	☐ Brain injury
☐ Heart trouble	☐ Epilepsy	☐ Emotional problems
☐ Rheumatic fever	☐ Prolonged bleeding	☐ Kidney/liver issues
☐ Thyroid problems	☐ Faintness/dizziness	☐ Ear aches
☐ Diabetes	☐ Tonsils removed	☐ Hepatitis

Does the patient have any medical alert conditions or allergies? _____

Does the patient have any medical concerns? _____

Physician's Name: _____

Please list any medications that the patient is currently taking:

_____

Females Only: Is the patient pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Does the patient have any behavioral or emotional conditions we should be aware of to better serve them?

☐ ADHD/ADD ☐ Autism Spectrum Disorder ☐ Anxiety Disorder ☐ Sensory Disorder ☐ Other: _____

INSURANCE INFORMATION

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Social Security Number/ID Number: _____

Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

AUTHORIZATIONS

Insurance Authorization: I authorize my insurance company to pay directly to Prettyman Orthodontics and their associate dentists my insurance benefits that would otherwise be payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I have received, read, understand, and accept the Insurance and Financial Policy of Prettyman Orthodontics. In addition, by signing below I agree to receive calls from Prettyman Orthodontics staff at work, home, or by mobile phone to discuss matters related to my dental treatment, insurance, and financial arrangements.

_____ _____

Patient/Legal Guardian Signature Date

Authorization for Treatment: I consent to the procedure decided upon to be necessary or advisable in the opinion of the Orthodontist.

_____ _____

Patient/Legal Guardian Signature Date

PRETTYMAN ORTHODONTICS

PRACTICE POLICIES

- We require 24 hour prior notice if you are unable to keep your scheduled appointment. We reserve the right to charge you a cancellation fee and/or dismiss you from the practice if you fail to comply with this policy.
- When we call to confirm our appointments, we ask our patients to confirm their appointment by return phone call, email or text message within 24 hours after receiving your confirmation notification. Failure to comply with this policy will mean you scheduled as an "unconfirmed stand-by" patient and you may or may not be seen if you show for your appointment.
- There is a $30.00 fee for transfer or release of patient's records, including x-rays.
- **Children may not be left alone** in the reception area and may not accompany you to the treatment rooms/area. Please arrange for child care prior to your appointment or we reserve the right to reschedule your appointment.
- **Only patients** are allowed in the treatment rooms/area. If the patient is a minor, the parent or legal guardian will be allowed to accompany the patient to the treatment room where the treating doctor will explain the diagnosis, planned treatment and risks and benefits of the treatment. When it comes time to deliver the treatment to the patient, it will be at the discretion of the treating dentist whether they will allow the parent/legal guardian to remain in the treatment room for the remainder of the appointment.
- Parent, legal guardian or nursing home staff must remain at the office during treatment if the patient is younger than 18 or is a resident or in the care of a group home, assisted living facility, nursing home or any other type of guardian care.
- Cell phone use is **NOT** permitted in the reception area or operatories. Please step outside of the building to use your cell phone.
- Food and beverage is not permitted in the reception area or operatories.
- Smoking is not permitted inside or within fifty (50) feet of the patient entrance.
- Weapons of any type (guns, knives, batons, etc), concealed or unconcealed, are not permitted inside.
- Please be considerate of others when talking. Patients who talk loudly or use inappropriate language may be asked to leave.

I understand and agree to conform to the above practice policies.

Print Name: _____ Date: _____

Patient/Legal Guardian Signature: _____

PRETTYMAN ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

We understand that your medical and dental information is personal and we are committed to protecting it. We create a record of the care and services at our office. We need this record to provide you with quality dental care and to comply with certain legal requirements. This notice will tell you about the way we may use and share your Protected Health Information (PHI).

Patient Rights: You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, the records will be sent as directed in a timely manner.

We have a legal duty to:

1. Keep your personal health information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current notice.
4. Notify you of an accidental disclosure of your private health information in a timely manner.

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

Notice of change to privacy practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following describes different ways that we use and disclose your medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose dental/medical information. We will not use or disclose your dental/medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. **For treatment:** We may use your PHI to provide you with dental treatment or services. We may disclose dental/medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
2. **For payment:** We may use and disclose your PHI for payment purposes. A bill may be sent to you or a third-party payer or collection agency. The information on or accompanying the bill may include dental/medical information.
3. **For health care operations:** We may use and disclose your PHI for our health care operations including quality assessments, evaluating the performance of employees and conducting training.
4. Prettyman Orthodontics may not sell or use your PHI for marketing or fundraising purposes without your signed authorization.
5. If you pay for your dental treatment and request that we disclose the procedure to your insurance company, we must comply with your request as long as you pay in full for the procedure in a timely manner.

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Name (Print): _____ Date: _____

Patient/Legal Guardian Signature: _____

Relationship to Patient: _____