Today's Date: ________________________

Patient Information

Patient's Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Date of Birth: ______________ Sex: Male / Female

Cell Phone: ______________________________

Home Phone: ______________________________

Other Phone: ______________________________

School: ______________________________

Interests/Activities: ______________________________

Dentist: ______________________________

Last Cleaning: ______________________________

Physician: ______________________________

Who is with the child today (if applicable)?

Name:____________________ Relationship: __________

Do you have any other family members in treatment here?

____

Name and Ages of other children: ____________________

____

What do you hope to accomplish with braces? ______________

____

Is this your 1st visit to an orthodontist? ________________

Parent's marital status? __________________________

Person responsible for financial account? ______________

How did you hear about our office? __________________

Mother's Information (if applicable) Father's Information

Mother's Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Cell Phone: ____________ Work #:____________

Home Phone: ______________________________

Email Address: ______________________________

Father's Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Cell Phone: ____________ Work #:____________

Home Phone: ______________________________

Email Address: ______________________________

Dental Insurance Coverage

Do you have Orthodontic Insurance coverage? Yes ☐ No ☐

If yes, name of Dental Insurance Carrier: ____

Group #: ______________________________ Member ID #: ______________________________

Subscriber Name: __________________________ Subscriber Date of Birth: ______________________

Subscriber Social Security #: ____________________ Subscriber Employer: ______________________

I authorize release of any information to the insurance company and insurance payment directly to Schulten Orthodontics.

Signature: ____

Health History

How often does the patient see their dentist? ______________

How many times a day does the patient brush? _____________

Is the patient in good health? ____________________________

Is the patient under the care of a physician? _______________

Is so, for what? _______________________________________

Please list medications the patient is currently taking:

____

List any allergies, including latex: _________________________

Have there been any injuries to the face, mouth or teeth? ____

If so, explain: ____

____

Are there any problems with the jaw?

Clicking ____ Pain _____ Opening ____ Chewing ____

Has Patient sucked thumb or fingers? Yes ___ No____

Until What age? _________

Any Speech problems? _________________________________

Mouth breather? ______________________________________

Have you been informed of any missing or extra teeth?

____

Please circle appropriately:

Has patient ever had any of the following?

Diabetes	Yes / No
Seizures	Yes / No
Heart Murmur	Yes / No
Mitral Valve Prolapse	Yes / No
Hepatitis	Yes / No
Asthma	Yes / No
Fainting or Dizziness	Yes / No
Frequent Headaches	Yes / No
Jaw popping or locking	Yes / No
Clenching or grinding	Yes / No
Bone Disorder	Yes / No
Tonsils or adenoids removed	Yes / No
Bleeding gums or periodontal disease	Yes / No
Previous orthodontic treatment	Yes / No
Reached puberty	Yes / No

Other:____

____

I confirm the above information to be correct. I understand it is my responsibility to notify Schulten Orthodontics of any changes in the health history or personal information of the patient in treatment. I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment.

Signature: ____ **Date:** _____________________

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information and to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our notice is available with this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of the protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, at any time, by contacting our office.

I have had full opportunity to read and consider the contents of this consent form and your 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.

Signature: ____ **Date:** _____________________________

May we use the patients name and/or photo in our practice newsletter, office bulletin board and/or Social Media? Yes ____ No____

Signature: ____ **Date:** _____________________________