



### Confidential Patient Information

Patient's Name \_\_\_\_\_  
Last First Middle  
Address \_\_\_\_\_  
Street City State Zip  
Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
If patient is a minor, give parent or guardian's name \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

### Confidential Responsible Party Information

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle  
Residence \_\_\_\_\_ Own Rent  
Street City State Zip  
Mailing Address \_\_\_\_\_  
Street City State Zip  
Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Insurance Information

Policy Holder's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Employer: \_\_\_\_\_ ID No. \_\_\_\_\_  
Do you have dual coverage? Yes  No  If yes:  
Policy Holder's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ ID No. \_\_\_\_\_ Policy Holder's Employer \_\_\_\_\_

### Emergency Information

Name of nearest relative not living with you \_\_\_\_\_  
Complete Address \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature (Parent's signature if minor) \_\_\_\_\_  
Updates (date & initial)

## Orthodontic History

PLEASE ANSWER ALL QUESTIONS FOR THE PATIENT IF HE/SHE IS A MINOR AND FOR YOURSELF IF YOU ARE THE PATIENT.

Describe in your own words what you understand the orthodontic problem to be: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Is this your first orthodontic evaluation? \_\_\_\_\_

Has anyone in the family received orthodontic treatment by another orthodontist? \_\_\_\_\_

How did they feel about the result? \_\_\_\_\_

Names of any family members we have treated: \_\_\_\_\_

What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_

## Dental History

Dentist: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

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

Please circle Yes or No (if Yes, please fill in details)

Yes No Have you ever had a bad experience in a dental office? Describe: \_\_\_\_\_

Yes No Have you ever chipped or lost any teeth? \_\_\_\_\_

Yes No Have there been any injuries to your face, mouth, or teeth? \_\_\_\_\_

Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_

Yes No Do your gums bleed when you brush? \_\_\_\_\_

Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_

Yes No Are you a mouth breather? \_\_\_\_\_

Yes No Have your tonsils and/ or adenoids been removed? At what age? \_\_\_\_\_

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_

Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_

Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_

Yes No Have you ever been told that you grind your teeth at night? \_\_\_\_\_

Yes No Do you have "tension" headaches? \_\_\_\_\_

Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_

Yes No Have you ever been told you have TMJ problems? \_\_\_\_\_

## Medical History

Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Weight: \_\_\_\_\_

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

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medication? \_\_\_\_\_

Yes No Are you allergic to any medication? \_\_\_\_\_

Yes No Are you allergic to any metal or latex? \_\_\_\_\_

Yes No Have you ever had a major illness? \_\_\_\_\_

Yes No Have you had any major operations? \_\_\_\_\_

Yes No Have you ever been involved in a serious accident? \_\_\_\_\_

Yes No Have you ever taken any Bisphosphonates? *Actonel/Riserdronate, Aredia/Pamidronate, Didronel Etidronate, Fosamax/Alendronate, Skelid/Tilndronate, Zoledronic Acid*

Circle any of the medical conditions you may have.

Abnormal bleeding/ Hemophilia	Diabetes	Hepatitis/ Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV+/ AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that we should be aware of? \_\_\_\_\_

**X Signature** (Parent's signature if minor) \_\_\_\_\_

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

**PRIVACY CONSENT**

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form. Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office’s privacy notice prior to signing this consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent. Thank you for your cooperation. Please let us know if you have any questions.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**PATIENT PHOTO RELEASE**

Patient Name \_\_\_\_\_

The above named patient (or parents/legal guardian) of Boerne Orthodontics and Pediatric Dentistry, consent to authorized the use and reproduction of photographs and audiovisual material whenever print or electronic format. I understand that these pictures, name, and only may appear in such publicity material for promotional and educational purposes only.

I accept to having my photo released

I decline to have my photo released

\_\_\_\_\_  
Signature