Date: _____/_____/_____ Patient's Full Name: _____ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Address: _____

City: _____State: _____ Zip code: _____

Home phone: (_____)_____ Cell phone: (_____) _____

Father's name: (if patient is adolescent) _____ Address: _____

Mother's name: (if patient is adolescent) _____ Address: _____

Marital Status of parent(s) or if patient is over 18 years of age.

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Emergency contact (name): _____ phone: (_____)_____

RESPONSIBLE PARTY INFORMATION

Name: _____ Birthdate: _____/_____/_____

Occupation_____

Relationship to patient: _____ Email: _____

Home phone: (_____)_____ Cell phone: (_____)_____

ORTHODONTIC INSURANCE INFORMATION

Primary Orthodontic Insurance:

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone# (_____) _____

Group# (Plan, Local or Policy): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

SSN# or ID#: _____

Employer Name: _____

Secondary Orthodontic Insurance:

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone# (_____) _____

Group# (Plan, Local or Policy): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

SSN# or ID#: _____

Employer Name: _____

Insurance information cannot be verified unless the policy holders ID# or Social Security# is provided.

Dentist: _____ City: _____ Phone: (_____) _____

Date of last dental check-up? _____ How many times do you brush your teeth daily? _____

What is your main orthodontic concern: _____

Has the patient ever had an orthodontic examination before? ☐ yes ☐ no If yes, when? _____

Does the patient have any missing, or extra, permanent teeth? ☐ yes ☐ no Which teeth? _____

Has the patient had pain/tenderness in the jaw joint (TMJ/TMD)? ☐ yes ☐ no When? _____

Personal Physician:_____City:_____Phone: (_____)_____

Please list any medications that the patient is currently taking: _____

Has puberty started (if patient is adolescent): ☐ yes ☐ no If female adolescent, has menstruation started? (related to growth) ☐ yes ☐ no

MEDICAL-DENTAL HISTORY

Abnormal Bleeding:	☐ yes ☐ no	Convulsions/Epilepsy:	☐ yes ☐ no	Mouth Breathing:	☐ yes ☐ no
ADD/ADHD:	☐ yes ☐ no	Kidney Problems:	☐ yes ☐ no	Tongue Thrusting:	☐ yes ☐ no
Asthma:	☐ yes ☐ no	Handicaps/Disabilities:	☐ yes ☐ no	Hearing Impairment:	☐ yes ☐ no
Allergy to Drugs:	☐ yes ☐ no	HIV+/AIDS:	☐ yes ☐ no	Thumb/Finger Sucking	☐ yes ☐ no
Allergies to Latex:	☐ yes ☐ no	Tuberculosis (TB):	☐ yes ☐ no	Cancer/ Radiation/Chemotherapy	☐ yes ☐ no
Allergy Nickel/Metal	☐ yes ☐ no	Diabetes	☐ yes ☐ no	Clench/Grind Teeth	☐ yes ☐ no
Any Operations:	☐ yes ☐ no	Heart Problems/Heart Murmur:	☐ yes ☐ no	Lupus:	☐ yes ☐ no
Hemophilia:	☐ yes ☐ no	Congenital Heart Defect	☐ yes ☐ no	Bone Disorders	☐ yes ☐ no

Other significant comments: _____

Whom may we thank for referring you to our office? _____

Patient Signature_____Date_____

SIARA-OLDS ORTHODONTICS

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2008 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payers examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to our consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PATIENT ACKNOWLEDGEMENT

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today been offered a copy of our notice of privacy practices.

I acknowledge that I have today been offered a copy of the Notice of Privacy Practices.

Patient Signature_____ Patient Name_____

(or parent if patient is a minor)

Date_____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient from signing the Acknowledgement.

Office Personnel (signature)_____ Office Personnel (print name)_____ Date_____

PATIENT CONSENT

Please sign this form below under the heading "Consent" to consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature_____ Patient Name_____

Date_____