CONFIDENTIAL

Medical/Dental History Form (Child)

Date _____

PATIENT

Patient's last name _____ First name _____ Middle initial _____

☐ Male ☐ Female

Prefers to be called _____ Birth date _____

Home address _____

_____

Home phone _____ Cell phone _____

Email address _____

School _____

PARENT/GUARDIAN

Father/Stepfather's full name _____

Occupation _____ Employer _____

Address (if different) _____

Phone (if different) _____ ☐Home ☐Cell

Mother/Stepmother's full name _____

Occupation _____ Employer _____

Address (if different) _____

Phone (if different) _____ ☐Home ☐Cell

DENTIST/PHYSICIAN

Patient's Dentist _____ Date last seen _____

Other dental specialists: Name/reason _____

Patient's Physician _____ Date last seen _____

Specialty physicians and specialty _____

GENERAL INORMATION

What are your concerns about your child's teeth? _____

How does your child feel about orthodontics? ☐ Excited ☐ Unconcerned ☐ Nervous/anxious

How often does your child brush? _____Floss? _____

Who suggested that your child might need orthodontic treatment? _____

How did you hear about our office? _____

In the past have you consulted with another orthodontist? ☐ Yes ☐ No

Name/Date _____

Hobbies, activities, musical instruments _____

Do you think that any of your child's activities affect his/her face, teeth or jaws? ☐Yes ☐No

How? _____

Siblings:

Brother/sister name _____ Age _____

Had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Brother/sister name _____ Age _____

Had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Other siblings names? _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Home Address (if different from Page 1) _____

Phone _____ Email address _____

DENTAL INSURANCE

Primary policyholder's full name _____

Birth date _____ Social Security # _____

Relationship to patient _____ Employer _____

Insurance company _____ Ins. Phone # _____

Group # _____ ID # _____

Insurance claim address _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policyholder's full name _____

Birth date _____ Social Security # _____

Relationship to patient _____ Employer _____

Insurance company _____ Ins. Phone # _____

Group # _____ ID # _____

Insurance claim address _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

MEDICAL HISTORY

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

For the following questions, please mark Yes, No or Don't Know (DK) if your child has or has had:

Yes	No	DK	
			Birth defects or hereditary problems?
			Any major injuries to the face head or neck?
			Arthritis or joint problems?
			Cancer, tumor, radiation treatment or chemotherapy?
			Endocrine or thyroid problems?
			Diabetes?
			Kidney problems?
			Stomach problems, ulcers, hyperacidity, or acid reflux?
			Immune system problems?
			History of osteoporosis?
			AIDS or HIV positive?
			Hepatitis, jaundice or other liver problems?
			Mononucleosis, tuberculosis, pneumonia?
			Seizures, fainting spell, neurologic problem?
			ADHD, depression or other mental health disorder?
			History of eating disorder (anorexia, bulimia)?
			Frequent headaches or migraines?
			High or low blood pressure?
			Excessive bleeding or bruising tendency, anemia?
			Chest pain, shortness of breath, tire easily, swollen ankles?
			Heart defects, heart murmur or rheumatic heart disease?
			Angina, arteriosclerosis, stroke or heart attack?
			Skin disorder (other than common acne)?
			Vision, hearing, or speech problems?
			Frequent ear infections, colds, throat infections?
			Asthma, sinus problems, hay fever?
			Tonsil or adenoid condition?
			Does your child currently have (or ever had) a substance abuse problem?
			Does your child smoke or chew tobacco?
			Has your child ever taken any medications to strengthen their bones?
			Has your child ever taken oral or intravenous bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate), Zometa (zolendromic acid) or Aredia (pamidronate) for bone disorders or cancer?
			Any other problems? Pleas explain:

List any prescription medications, non-prescription medicines, herbal or supplements your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Has your child had allergies or reactions to any of the following?

Yes	No		Yes	No	
		Local anesthetics (novocaine, lidocaine, ect.)			Latex (gloves, balloons)
		Aspirin or Ibuprofen (Motrin, Advil)			Acrylic
		Penicillin or other antibiotics- List below			Foods
		Metals (jewelry, clothing snaps)			Other-Please list below

Other allergies: _____

DENTAL HISTORY

Now or in the past, has your child had:

Yes	No	
		Supernumerary (extra) or congenitally missing teeth?
		Chipped or injured primary or permanent teeth?
		Any sensitive or sore teeth?
		Jaw fractures, cysts, infections?
		Any teeth treated with root canals or pulpotomies?
		Frequent canker sores or cold sores?
		History of speech problems or speech therapy?
		Mouth breathing habit, difficulty breathing through the nose or snoring at night?
		Frequent oral habits (sucking finger/thumb, chewing pen, etc.)?
		Teeth causing irritation to lip, cheek or gums?
		Abnormal swallowing (tongue thrust)?
		Tooth grinding or clenching?
		Clicking, locking in jaw joints?
		Soreness in jaw muscles or face muscles?
		Ringing in ears, difficulty in chewing or opening jaw?
		Has your child been treated for “TMJ” or “TMD” problems?
		Has your child ever been told to take antibiotics before dental treatment.
		Any serious trouble associated with previous dental treatment?
		Has your child ever been diagnosed with gum disease?
		Have you noticed any unusual changes to your child’s face or jaws?

Is there any family history of:

☐Yes ☐No Unusual dental problems or congenitally missing teeth
☐Yes ☐No Jaw size imbalance or jaw surgery

Please explain: _____

RELEASE AND WAIVER

I authorize release of any information regarding my child’s orthodontic treatment to their dentist/dental specialists and my dental insurance company.

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child’s medical or dental health.

Parent/Guardian Signature _____ Date _____

Orthodontist Signature _____

Welcome to our practice!

Thank you so much for selecting Caudill Orthodontics. We are very pleased to have you as a patient and hope to make this a pleasant experience for you!

We are obsessed with personalized, quality customer service and prompt appointments. We openly welcome any questions or suggestions you may have. Here are a few important items to get you started with us.

What's in this packet?

Enclosed in this packet are all the medical, financial and other good-to-know bits of information about our practice. No worries, there won't be a quiz, but we do need for you to bring some important items to your first appointment.

Your First Appointment Checklist

Please bring the following items completely filled out and signed:

1. Medical/Dental History Form
2. Privacy Notice Sheet
3. Referral Information Sheet
4. Referral from your dentist (if you have one)

We're on Facebook

Ok, so we admit we just love social media and like to have fun, so why not join in! Become a Fan of Caudill Orthodontics on Facebook, relax and enjoy the benefits. We also occasionally run contests, fun promotions and events and would love to have you participate. Upload photos of you in your Caudill t-shirts to win cool swag and even extra tokens that can earn you iTunes cards, prizes and local gift certificates!

FREE Wifi - Both locations have FREE Wifi for you to surf the net and update your Facebook status during your visits. See you online!

Find us at www.Facebook.com/CaudillOrthodontics

Financial and Insurance Information

Your treatment at Caudill Orthodontics is an investment that will last a lifetime. We understand that orthodontic treatment is a significant financial commitment. That is why we offer different payment plans and options to accommodate your financial budget.

Credit/Debit Cards

For your convenience, we accept MasterCard, Visa, Discover and debit cards.

Insurance

For those with orthodontic insurance benefits, our Financial Coordinator verifies, prepares and files the necessary paperwork. We will work with your insurance company to ensure that you receive all of your orthodontic benefits. By assigning your benefits directly to us, we will deduct these benefits from your remaining balance.

Please be aware, however, that our primary financial relationship is with our patients and their families and not with their respective insurance companies. Financial arrangements can be made based on your estimated insurance benefits, however, any outstanding insurance claims not paid are the responsibility of the patient/responsible party.

Please notify our office when you become aware that the insurance benefit has been discontinued or changed. We will notify you if we receive information about a change in benefits. Any amount of the estimated insurance benefit that the carrier does not pay will be added to your remaining account balance.

Financing Available

In-House Financing
Our in-house office financing offers an initial down payment with low monthly payments, interest-free!

Care Credit (3rd party financing)
Care Credit financing is also available with no interest, if paid within the promotional period of 6 or 12 months.

Pay-In-Full, Receive Additional Discounts

If you prefer to pay in-full at the start of orthodontic treatment, additional discounts are given. We also offer a family discount on additional, immediate family members having orthodontic care with us. And who doesn't love a discount?

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a
- copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient Name _____

_____ _____

Patient /Parent or Guardian Signature **Date**

Referral Information

Thank you for choosing Caudill Orthodontics! We know you have many options for orthodontic care and we truly appreciate your business.

So, how did you find our practice?

The greatest compliment we ever receive is for someone to refer us a new patient. Please bring this sheet with you to your appointment.

WORD OF MOUTH
If it's a human, we'd love to thank them personally!

Name: _____

How do you know them? _____
(i.e. One of our Patients – Dentist or Doctor – Friend – Family Member – Co-Worker – Neighbor – Other)

INTERNET
Please check any place you might have found us on the Interwebs.

___ Google Search, Places or Maps
___ Yahoo
___ Invisalign.com
___ Yelp
___ Ask.com
___ YP.com
___ Facebook Page
___ Facebook Ads
___ Our website
___ Other website or social media _____

OTHER

___ Sports event or sponsorship
___ Print ad _____
___ Yellow Pages/ phone book
___ Drive-by/ saw outdoor sign
___ Written on the bathroom wall
___ Other _____

Thank you for your help. Your feedback is very much appreciated!