WELCOME

TO BAILEY ORTHODONTICS

PATIENT INFORMATION

Today's Date _____ [ ] Male [ ] Female

Name: _____

Nickname: _____ DOB: ___/___/_____

School: _____ Grade: _____

College Student: [ ]Full-time [ ]Part-time [ ]N/A

Home Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient is: [ ]Adult [ ]Child, and resides with:

[ ]Mother [ ]Father [ ]Other: _____

General Dentist: _____Last Visit: _____

Frequency of dental visits: _____

Whom may we thank for referring you?_____

IF PATIENT IS A CHILD, PARENT/GUARDIAN INFORMATION

Marital Status: [ ]Single [ ]Married [ ]Separated

[ ]Divorced [ ]Widowed

Mother's Name: _____

DOB: ___/___/_____ SSN: _____

Employer: _____

Work #: _____ Cell #: _____

Home #, if different than child: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Father's Name: _____

DOB: ___/___/_____ SSN: _____

Employer: _____

Work #: _____ Cell #: _____

Home #, if different than child: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PARENT/GUARDIAN/SELF

Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Relation: _____

Employer: _____

Work #: _____ SSN: _____

Email: _____

PRIMARY DENTAL/ORTHODONTIC INSURANCE

Orthodontic Coverage? [ ]YES [ ]NO [ ]UNSURE

Insurance Company Name: _____

Insurance Company Address: _____

City: _____State: _____ Zip: _____

Insurance Company Phone #: _____

Policy Holder: _____

Relationship to Patient: _____

Group #: _____ Policy #: _____

Policy Holder DOB: ___/___/_____ SSN: _____

Policy Holder's Employer: _____

SECONDARY DENTAL/ORTHODONTIC INSURANCE

Orthodontic Coverage? [ ]YES [ ]NO [ ]UNSURE

Insurance Company Name: _____

Insurance Company Address: _____

City: _____State: _____ Zip: _____

Insurance Company Phone #: _____

Policy Holder: _____

Relationship to Patient: _____

Group #: _____ Policy #: _____

Policy Holder DOB: ___/___/_____ SSN: _____

Policy Holder's Employer: _____

PATIENT'S CURRENT HEALTH:

PHYSICAL: [ ]Excellent [ ]Good [ ]Fair [ ]Poor

EMOTIONAL: [ ]Excellent [ ]Good [ ]Fair [ ]Poor

KNOWN OR SUSPECTED ALLERGIES:

[ ]Antiobiotics:_____

[ ]Other Medications:_____

[ ]Foods: _____

[ ]Environmental allergies: _____

[ ]Plastics [ ]Latex [ ]Metals: _____

[ ]NONE PLEASE INITIAL: _____

CURRENT MEDICATIONS:

[ ]Heart Medications [ ]Diet aids [ ]Vitamins [ ]Insulin

[ ]Birth Control Pills [ ]Muscle Relaxants

[ ]Antiobiotics: _____

[ ]Pain Medication: _____

[ ]Other: _____

[ ]NONE PLEASE INITIAL: _____

If the patient is a child, has puberty begun? [ ]Yes [ ]No

For girls, has menstruation begun? [ ]Yes [ ]No

Patient's Primary Care Physician: _____

Phone #: _____ Last Visit: _____

DOES/DID THE PATIENT HAVE ANY OF THE FOLLOWING HABITS?

[ ]Clenching/Grinding Teeth [ ]Nursing Bottle Habits

[ ]Lip Sucking/Biting [ ]Speech Problems

[ ]Mouth Breather [ ]Thumb/Finger Sucking

[ ]Nail Biting [ ]Tongue Thrust

[ ]Regularly snores

[ ]Sleep disturbance:_____

PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

[ ]Desires treatment [ ]Only if necessary [ ]Uncooperative

[ ]Unwilling but will cooperate if treatment is indicated

ORTHODONTIC EXAM PROMPTED BY:

[ ]Dentist [ ]Doctor [ ]Parent [ ]Spouse [ ]Sibling

[ ]Friend [ ]Self [ ]Other:_____

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

[ ]AIDS / HIV+ [ ]Asthma [ ]Autoimmune Disorders

[ ]Blood disease/Abnormal Bleeding [ ]Bone Disorders

[ ]High/Low Blood Pressure [ ]Diabetes [ ]Dizziness

[ ]Eating Disorders [ ]Endocrine Problems [ ]Hepatitis

[ ]Emotional Disorders [ ]Heart Disease [ ]Tuberculosis

[ ]Congenital Heart Defect [ ]Heart Murmers

[ ]Handicaps/Disabilities [ ]Kidney Disease [ ]Cancer

[ ]Rheumatic/Scarlet Fever [ ]Convulsions/Epilepsy

[ ]Ringing in the ears [ ]Liver Problems

[ ]Frequent sore throat / tonsillitis

[ ]Major Surgeries: _____

[ ]Hospital Admissions: _____

Comments: _____

_____

CHIEF ORTHODONTIC CONCERNS:

_____

_____

Please check all that apply:

[ ]Crowding [ ]Overbite [ ]"Buck Teeth"

[ ]Receded Jaw [ ]Prominent Jaw [ ]Gummy Smile

[ ]Neck Pain [ ]Space between teeth [ ]Stuffy/Ringing Ears

[ ]Pain or Difficulty chewing [ ]Headache/Face Pain

[ ]Gum disease/recession [ ]Jaw dysfunction [ ]Jaw Pain

[ ]Mouth too small [ ]Clicking Jaw Joint [ ]Irregular Teeth

[ ]Protrusion of Teeth [ ]Irregular Facial Appearance

[ ]Other: _____

FAMILY MEMBERS WITH SIMILAR CONDITIONS:

[ ]Father [ ]Mother [ ]Sibling [ ]Other: _____

Has the patient ever been evaluated for or had orthodontic treatment before? [ ]No [ ]Yes: _____

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

[ ]No [ ]Yes _____

Any musical instruments played: _____

Adenoids/Tonsils removed? [ ]Yes [ ]No

Any known missing or extra permanent teeth? [ ]Yes [ ]No

Tenderness/Pain in jaw joint (TMJ / TMD)? [ ]Yes [ ]No

Brush teeth daily? [ ]Yes [ ]No Floss Daily? [ ]Yes [ ]No

MEDICAL, DENTAL, OR SURGICAL INFORMATION
NOT COVERED ELSEWHERE ON THIS FORM?

PLEASE DESCRIBE: _____

_____

_____

_____

PLEASE LIST A RELATIVE OR FRIEND NOT LIVING WITH YOU

Name: _____ Relation: _____ Phone #: _____

Address: _____
STREET ADDRESS CITY STATE ZIP

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services my child may need.

Signature: _____ Date: _____

I hereby authorize Bailey Orthodontics to release all necessary information to secure payment of benefits and I assign directly to the doctor all insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submission. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature of patient or parent/guardian: _____ Date: _____

The parent or guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

HIPAA PRIVACY AUTHORIZATION FORM Patient Name: _____

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize Bailey Orthodontics and Dr. John H. Bailey to use and disclose the protected health information described below to my general dentist and other healthcare providers as needed for orthodontic treatment.

2. Effective Period

This authorization for release of information covers:

_____ all past, present, & future periods

OR

_____ the period of healthcare from _____ to _____.

3. Extent of Authorization

_____ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

_____ I authorize the release of my complete health record with the exception of the following information:

_____ Mental Health Records

_____Communicable Diseases (including HIV and AIDS)

_____ Alcohol/Drug Abuse Treatment

_____ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative: _____

Printed name & relationship to patient: _____ Date: _____