WELCOME TO THE ORTHODONTIST

Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____ ☐ M ☐ F
LAST FIRST MI

Birthdate: ___/___/___ Age: ____ SS #: _____

School: _____ Grade: ____

Hobbies / Sports: _____

Child's Home # (____) _____

Child's Home Address: _____

_____
CITY STATE ZIP

E-mail Address: _____

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

List other family members seen by us _____

_____

General Dentist: _____

Date of last cleaning / visit: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

3 Parental Information

☐ **Mother** ☐ Stepmother ☐ Guardian

Name: _____ Birthdate ___/___/___

Wk # (____) _____ Hm # (____) _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____ DL #: _____

☐ **Father** ☐ Stepfather ☐ Guardian

Name: _____ Birthdate ___/___/___

Wk # (____) _____ Hm # (____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Previous Address: _____

_____
CITY STATE ZIP

Hm # (____) _____ DL #: _____

Employer: _____

Wk # (____) _____ SS #: _____

Who is responsible for making appointments?

Name: _____ Wk # (____) _____

Cell # (____) _____ Hm # (____) _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

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: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

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: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

CONTINUED ON BACK

6

What would you like orthodontics to accomplish?

_____

Has your child ever taken Phen-Fen? ☐Y ☐N
(Redux or Pondimin) If yes, when? _____

Has your child ever been evaluated or had orthodontic treatment before? ☐Y ☐N

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐Y ☐N

Has your child been informed of any missing or extra permanent teeth? ☐Y ☐N

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐Y ☐N

Does your child brush his / her teeth daily? ☐Y ☐N

Does your child floss his / her teeth daily? ☐Y ☐N

Child's Physician: _____

Phone # (____)_____ Date of last visit: _____

Is your child under the care of a physician? ☐Y ☐N

Has puberty begun? ☐Y ☐N

Girls - Has menstruation begun? ☐Y ☐N

Please describe your child's current physical health: ☐Good ☐Fair ☐Poor

Please list all drugs that your child is currently taking:

_____ _____

Please list all drugs/things that your child is allergic to:

_____ _____

Latex Y N Metals/Nickel Y N Plastics Y N

7

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to Any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones / Joints	Y	N	HIV+ / AIDS
Y	N	Artificial Valves	Y	N	Kidney / Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

8

Has your child ever experienced any of the following?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing / Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Neighbor or Relative not living with you

Name _____ Ph # (____)_____

Address _____

_____
CITY STATE ZIP

9

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 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 the necessary dental services that my child may need.

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

If this office accepts insurance, 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. I hereby authorize payment of the group insurance benefits directly to this office.

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

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

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____ Initials: _____ Date: _____

_____

_____

_____

Beverly Hills Orthodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Beverly Hills Orthodontics

CONSENT FOR THE TRANSFER OF YOUR/YOUR CHILD'S HEALTH INFORMATION VIA EMAIL- EXAMPLES OF INFORMATION TO TRANSFERRED INCLUDE BUT ARE NOT LIMITED TO: RADIOGRAPHS, PHOTOGRAPHS, TREATMENT NOTES, WRITTEN CORRESPONDENCE REGARDING YOU OR YOUR CHILD'S TREATMENT

PLEASE NOTE: We are happy to respond to your request but in order for us to do so via email you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your request.

I, _____, authorize Beverly Hills Orthodontics and any all doctors and employees to send the requested information to the dental office below.

This consent form will also apply in the event you change your dentist of record, unless you direct otherwise.

Your name:

Your date of birth:

Patient name:

Patient date of birth:

Dentist name:

_____ _____

{Signature} {Date}

WELCOME TO BEVERLY HILLS ORTHODONTICS

Meet Dr. Cohen:

- She has 2 daughters
- Her favorite food is Italian
- She loves to dance, play piano and snuggle with her kids

Meet Dr. Madan:

- She has a son and 2 daughters
- Her favorite food is Asian
- She loves to play tennis, watch movies and snuggle with her kids

Now tell us about YOU:

My name is: _____

You can call me: _____

I have _____ brothers(s) and _____ sisters

I go to this school: _____

Favorite things to do: _____

Favorite sports: _____

Favorite music: _____

Favorite book: _____

Best Friend: _____

Favorite pet: _____

BEVERLY HILLS ORTHODONTICS

Welcome to Beverly Hills Orthodontics!

In order to serve you better, please take a moment to answer these few questions. It will help the doctors understand your situation and enable them to provide you with the best possible solution.

1. Have you (or your child) had any orthodontic treatment in the past?

2. Have you (or your child) had an orthodontic evaluation before? If so, why haven't you considered treatment before?

3. Why are you interested in an orthodontic evaluation? What is most important to you when considering orthodontic treatment?

4. How long have you considered orthodontic treatment? Why are you considering treatment now?

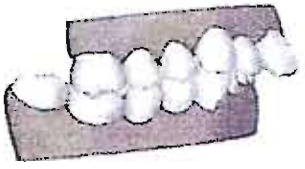
BEVERLY HILLS ORTHODONTICS

What is your main concern?

NAME: _____

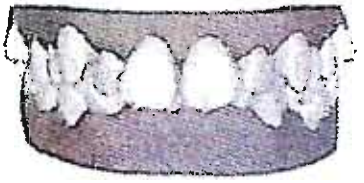
DATE: _____

Overjet (Buck teeth)



Spaced teeth

Crooked/Crowded teeth



OTHER (please fill in) _____

_____

What style of treatment would you prefer?

Metal Braces

Clear Braces

Invisalign