

Welcome



John D. Hiester, DDS, MSD

Child Information Sheet

Today's Date: _____

Patient Information

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____

City, State, Zip: _____

School: _____ Grade: _____

Interest/Activities: _____

Name & Ages of other Children in Family _____

Dentist: _____ Phone #: _____

Physician: _____ Phone #: _____

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

Responsible Party

Person Responsible for Account: _____

Social Security Number: _____

Father's Name: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Other phone: _____

Employed by: _____

Occupation: _____ Business phone: _____

E-Mail Address: _____ Marital Status: _____

Mother's Name: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Other phone: _____

Employed by: _____

Occupation: _____ Business phone: _____

E-Mail Address: _____ Marital Status: _____

Insurance Information

Do you have orthodontic Insurance Coverage? _____

Name of Insurance Co.: _____

Mailing Address: _____

Phone #: _____

Policy Holder: _____ DOB: _____

SS #: _____

Employer: _____

Group #: _____ Patient ID #: _____

Medical History

Has the patient ever been treated for any of the following?

Diabetes _____	Asthma _____
Pneumonia _____	AIDS/HIV _____
Heart Trouble _____	Kidney Involvement _____
Hepatitis _____	Prolonged Bleeding _____
Rheumatic Fever _____	Fainting, Dizziness _____
Bone Disorder _____	Nervous Disorder _____
Headaches _____	Psychiatry _____
Endocrine _____	Genetics _____
Anemia _____	Skin Disorders _____
Epilepsy _____	Other _____

Is the patient in good health? _____

Is there any history of major illness or surgery? _____

Is there a tendency to have colds? _____

Sore throats _____ Ear infections? _____

Allergies or drug sensitivities? _____

Latex Allergies? Y N

Have tonsils and adenoids been removed? _____ Age? _____

Has patient received a blood transfusion since 1980? _____

Has patient been exposed to the AIDS virus? _____

Have you been advised to be premedicated? _____

If so, please explain. _____

Current medications? _____

Reason? _____

Has patient reached puberty? _____

Are there any problems with the jaw?

Clicking _____ Pain _____ Opening _____ Chewing _____

Has there been any injuries to the face, mouth or teeth?

Explain _____

Has patient ever sucked thumb or fingers? _____

Until what age? _____

Any speech problems? _____ Mouth breather? _____

While awake or asleep? _____

Have you ever been informed of any missing or extra teeth?

Explain _____

Have you seen another orthodontist? _____

Has any member of the family received orthodontic treatment?

Reason for consultation? _____

I authorize the information to be correct. I understand it is my responsibility to notify American Family Orthodontics of any changes in my health history.

Signature

Date

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this Consent. Our Notice; provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving this office written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that *we may decline to treat you or to continue treating you if you revoke this Consent.*

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature

Date