Young at Heart Orthodontics

PATIENT INFORMATION

Name _____ Date_____
Nickname _____ Social Security # _____
Address _____
City _____ State_____ Zip_____
Birthdate_____ Age_____ [ ] M [ ] F
Patient Phone # _____Cell Phone Provider_____
General Dentist _____

Referral
WHO MAY WE THANK FOR REFERRING YOU?
[ ] Dentist _____
[ ] Friend _____
[ ] Other _____

Responsible Party Information (If the Patient is a Minor)

Mother or Guardian

Name _____ Social Security #_____
Birthdate_____ Relationship to Patient_____
Address (If Different from Above) _____
City _____ State_____ Zip_____
Phone # _____ Cell Phone Provider_____
Employer _____

Father or Guardian

Name _____ Social Security #_____
Birthdate_____ Relationship to Patient_____
Address (If Different from Above) _____
City _____ State_____ Zip_____
Phone # _____ Cell Phone Provider_____
Employer _____

Permission Form (If the Patient is a Minor)

The following person(s) are allowed to accompany my child to his/her appointment and make any/all dental decisions in the best interest of my child/children at their orthodontics visits until further notice.

Name: _____Relationship to Patient_____
Name: _____Relationship to Patient_____
Name: _____Relationship to Patient_____
Name: _____Relationship to Patient_____

DENTAL INSURANCE

Primary Insurance Company _____
Insured Name _____
Social Security # _____
Birthdate_____
Employer_____

Secondary Insurance Company_____
Insured Name _____
Social Security # _____
Birthdate _____
Employer _____

Medical History

Yes No Heart Murmur
Yes No Asthma
Yes No Rheumatic Fever
Yes No Tuberculosis
Yes No Prolonged Bleeding
Yes No Cancer
Yes No Anemia
Yes No Growth Disorders
Yes No Kidney Disease
Yes No Disabilities
Yes No Liver Disease
Yes No Emotional Problems
Yes No Diabetes
Yes No Fever Blisters
Yes No Hepatitis
Yes No Allergies to Latex/Metal
Yes No Epilepsy
Yes No Allergies to Medication _____
Yes No Other Allergies _____
Yes No Fainting

Medication/What For: _____
_____

Have tonsils or adenoids been removed? Yes No
Any Health issues we should know about? Yes No
If so: _____

Please indicate history of:
Yes No Thumb/Finger Sucking
Yes No Jaw Joint Problems
Yes No Mouth Breathing
Yes No Frequent Headaches
Yes No Tongue Thrust
Yes No Speech Problems

I certify that the information that I have given today is complete and accurate. I understand that it is my responsibility to inform the office of any changes.

Signature of Patient/Parent or Guardian _____ **Date** _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Book" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect the privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal records.

Release Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.
Patient/Parent/Guardian Signature _____ Date _____

I've read and understand the questions above. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.
Patient/Parent/Guardian Signature _____ Date _____

I give permission to YAH Orthodontics, INC to display before/after photos or contest winner photos of my child's treatment in or around the office.
Patient/Parent/Guardian Signature _____ Date _____

You may refuse the consent to the use of disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objection to this form, please ask to speak to our Office Manager.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.