



Patient Information

Name _____ Sex M F
Last First Middle

Address _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security _____
MM-DD-YYYY 999-99-9999

Home Phone _____ General Dentist _____ Last Visit _____
999-999-9999

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

Responsible Party Information

Name _____ Birthdate _____ Marital Status _____
MM-DD-YYYY

Address _____

E-Mail _____ Social Security _____
999-99-9999

Home Phone _____ Cell Phone _____ Cell Carrier _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____

Name _____ Birthdate _____ Marital Status _____

Address _____

E-Mail _____ Social Security _____

Home Phone _____ Cell Phone _____ Cell Carrier _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____

Insurance Information

Policy Owner's Name _____ Policy Owner's Employer _____

Insurance Company _____ Group No. _____ ID No. _____

Insurance Co. Address _____ Insurance Phone No. _____

Do You have Dual Coverage? Yes No

Policy Owner's Name _____ Policy Owner's Employer _____

Insurance Company _____ Group No. _____ ID No. _____

Insurance Co. Address _____ Insurance Phone No. _____

Emergency Contact

Name _____ Relationship _____

Complete Address _____ Phone Number _____

Medical History

Is the patient currently under the care of a physician? Yes No

Medical Physician _____ Phone _____ Last Visit _____

Has the patient had their tonsils and adenoids removed? Yes No

Medication:
List all drugs patient is allergic to:

List all drugs patient is currently taking:

Has the patient ever had any of the following medical problems? (circle)					
Heart murmur	Y	N	Congenital Heart Defect	Y	N
Cancer	Y	N	Convulsions/Epilepsy	Y	N
Diabetes	Y	N	Abnormal Bleeding	Y	N
Rheum. Fever	Y	N	Hearing Impairment	Y	N
HIV+/AIDS	Y	N	Any Operations	Y	N
Hemophilia	Y	N	Any Stays in Hospital	Y	N
Asthma	Y	N	Kidney/Liver Problems	Y	N
Hepatitis	Y	N	Handicaps/Disabilities	Y	N
Tuberculosis	Y	N	Allergies	Y	N
Prosthesis	Y	N	History of Scarlet fever	Y	N

Are there any medical conditions we have not discussed that you feel we should be aware of? If yes, please describe.

Dental History

Does/Has the patient ever had any of the following habits?	Lip Sucking/Biting	Nail biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrust	Thumb/ Finger Sucking

Has the patient ever seen an orthodontist? Yes No

Has anyone in the family ever had orthodontic treatment? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever experienced pain in the jaw joint (TMJ/TMD)? Yes No

Has the patient ever had an injury to: (select all that apply) Teeth Mouth Chin

What is the main thing you would like to find out by coming to see Dr. Lauren and what would you like to see done for your smile?

Signature

I understand that information that I have provided is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform the office of any changes in my/my child's medical status. I also authorize the dental staff to perform the necessary dental services I/my child may need. I understand that where appropriate, credit bureau reports may be obtained.

Signature of patient/guardian

Date

OFFICE USE ONLY--OFFICE USE ONLY--OFFICE USE ONLY

I have reviewed the medical/dental information above with the parent/patient & patient names herein.

Doctor's Comments:



HIPAA CONSENT FORM

Advanced Orthodontics
2202 State Ave, Suite 200
Panama City, FL 32405

Patient Name _____

Patient Date of Birth _____

HIPAA- Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Advanced Orthodontics may use or disclose your protected health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Our Notice of Privacy Practices is available for you to view on our website, www.advancedorthodontics.info, or a copy can be obtained by contacting our office. Signing below indicates that you have had the opportunity to review the Notice of Privacy Practices.

Unencrypted 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 may contact you by mail, telephone or email. You may, at any time, opt out of these communications by contacting the office. We will use the minimum necessary amount of protected health information in any communication.

(initial) I certify that I have had the opportunity to review the Notice of Privacy Practices of Advanced Orthodontics.

(initial) I give Advanced Orthodontics permission to discuss treatment with anyone who brings me/my child to appointments.

Name of Responsible Party _____

Relationship to Patient _____

Signature _____

Date _____

Welcome to our Practice!



In an attempt to get to know you better, we request that you take a moment to complete the following information.

Name or nickname you like to be called: _____

Favorite kind of music/musical artist/musical group: _____

Foods you like best: _____

Activities you enjoy: _____

Pet(s): _____ Kind: _____ Name(s): _____

Grade: _____ School: _____

What do you like best about school? _____

When you look at your smile in the mirror, what would you like to improve upon? _____

Do you have any brothers or sisters? If yes, what are their names and ages?

Please share with us something special about yourself: _____

**Thank you for sharing this information with us.
We look forward to meeting with you soon!**