Patient Information (Please fill out form completely)

Date____________________

Patient's Full Name ______________________ Likes to be Called __________

First Middle Last

Sex ________ Age ________ Birth Date ________ School ______________ Grade ______

Home Address ______________________ City ______________ Zip ______

Father's Name ______________________ Employed By ______________________

Home# ______________ Wk# ______________ Cell# ______________

Mother's Name ______________________ Employed By ______________________

Home# ______________ Wk# ______________ Cell# ______________

Marital Status of Parents ____________ Custodial Parent (If Divorced) ____________

Step Father's Name ______________________ Wk# ______________ Cell# ______________

Step Mother's Name ______________________ Wk# ______________ Cell# ______________

Family Dentist ______________________ Date of Last Cleaning ______________

Physician ______________________ Patient's Hobby or Special Interests ______________

Parent's E-mail ______________________ Who referred you to our office? ______________

In case of emergency, name of nearest relative not living with you ______________________

Complete address ______________________ Telephone ______________

Have Tonsils and Adenoids Been Removed? (At What Age?______) ______________ Yes ❑ No ❑

Has the Patient Ever Sucked a Thumb or Finger? (Until What Age?______) ______________ Yes ❑ No ❑

Does the Patient Have Any Speech Problem? ______________ Yes ❑ No ❑

Is the Patient a Mouth Breather? ______________ Yes ❑ No ❑

Does the Patient Play a Musical Wind Instrument? (Which?______________) ______________ Yes ❑ No ❑

Has the Eruption of the Teeth Seemed Normal? (Early ❑ Late ❑) ______________ Yes ❑ No ❑

Is Patient in Good Health? ______________ Yes ❑ No ❑

Does the Patient Have a History of any Major Condition or Illness? ______________ Yes ❑ No ❑

If yes, please list: ______________________

Please List Any Allergies or Drug Sensitivities ______________________

Responsible Party Information

Name ______________________

First Middle Last Marital Status

Address ______________________ City ______________ State ______ Zip ______

How long at this address ________ Own or Rent ________ Home Phone ____________ Work Phone ____________

Previous Address (if less than 3 yrs.) ______________ City ______________ State ______ Zip ______

Social Security # ______________ Birth Date ______________ Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ______________

Spouse's Name ______________________

Spouse's Employer ______________________

Occupation ______________ Years Employed ______________ Work Phone ______________

Insurance Information

Insured's Name ______________________ Insured's Soc. Sec. # ______________

Insurance Company ______________ Group No. ______________ Phone No. ______________

Insurance Co. Address ______________________

Do you have dual coverage? Yes ❑ No ❑ If yes:

Insured's Name ______________________ Insured's Soc. Sec. # ______________

Insurance Company ______________ Group No. ______________ Phone No. ______________

Insurance Co. Address ______________________

Insured's Employer ______________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature, if minor) ______________________

Updates (date & initial) ________ ________ ________ ________ ________

CHILD - GREEN

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? .... Yes No
   If yes, for what? ____________________
   Physician's Name ____________________ Phone ____________________
   Address ____________________ City ____________ State ________ Zip ________
2. Have you taken any medication or drugs during the past two years? .... Yes No
3. Are you taking any medications, drugs or pills now? .... Yes No
   If yes, please list

Medication	Dose	Reason
1.		
2.		
3.		
4.		

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? .... Yes No
   If yes, please list: ____________________
5. Have you been a patient in the hospital during the past five years? .... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores / Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special / Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous / Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric / Psychological Care	Yes	No

7. Have you lost or gained more than 10 pounds in the past year? .... Yes No
8. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
   If yes, please list: ____________________
9. **WOMEN** - Are you: Pregnant? ____ Yes, Months No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature ____________________ Date ____________

History Review

Doctor Signature ____________________ Date ____________

MAHLMANN & BORDERS ORTHODONTICS
The Art of Orthodontics

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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. i.e. contact with your dentist, physician, pediatrician or oral surgeon, etc. from our office. Also to include contact with Insurance Companies and Electronic transactions.

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.

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.

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 heath care operations.

Patient's Name: ____

Email: ______________________________________

Patient, Parent or Guardian Signature

Signature: _________________________________Date: _________________________

If this Consent is signed by a legal guardian or representative on behalf of the patient, complete the following:

Legal Guardian or Representative's Name: ______________________________________

Relationship to Patient: ____

Please sign this form and return with Medical information and Patient History Form at exam appointment.