ORTHOSTYLE
BY DR. MINA

CHILD PATIENT INFORMATION

PATIENT NAME_____
First Middle Last

Gender____ DOB_____ Age____ School_____ Grade_____

Home address_____
Street City State Zip

Patient's Interests:_____

Please describe your child's orthodontic concern_____

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

Patient dentist_____ phone number_____

Family Information

Father _____DOB_____
First Middle Last

Cell# (_____)_____ -_____ Cell phone Carrier_____ Email_____

Home address_____

Employer_____ Occupation_____ Work#(_____)_____ -_____

Business address_____

Mother_____DOB_____
First Middle Last

Cell#(_____)_____ -_____ Cell Carrier_____ Email_____

Home address_____

Employer_____ Occupation_____ Work#(_____)_____ -_____

Business address_____

Parent's Marital Status: Married_____ Separated_____ Divorced_____ Widowed_____ Single_____

Patient Resides with:_____ Both___ Other_____

Welcome to ORTHOSTYLE by Dr. Mina! Please complete this form as accurately as possible. It is important for us to have this information in order to provide the best possible care for your child. Your privacy is important to us. The information you share with us will remain strictly confidential.

CHILD MEDICAL HISTORY

Physician's Name_____**Address**_____**Phone**_____
Is your child currently taking any medications? □ YES □ NO **List:** _____
Is your child allergic to any medications? □YES □ NO **List:**_____
Does your child have any other allergies? □YES □ NO **List:**_____
Has your child's tonsils or adenoids been removed? □YES □ NO **List:**_____

Please check if you have had any of the following conditions:

AIDS/HIV	□YES □ NO	**Growth Disorders**	□ YES □ NO	**Prone to ear infections**	□ YES □ NO
Anemia	□YES □ NO	**Heart Condition**	□ YES □ NO	**Prone to sore throats**	□ YES □ NO
Asthma	□YES □ NO	**Heart Murmur**	□ YES □ NO	**Prolonged Bleeding**	□ YES □ NO
Behavioral Issues	□YES □ NO	**Hearing Impaired**	□ YES □ NO	**Psychiatric Care**	□ YES □ NO
Bone Disorder	□YES □ NO	**Hepatitis Type**	□ YES □ NO	**Rheumatic Fever**	□ YES □ NO
Blood Disease	□YES □ NO	**Hernia Repair**	□ YES □ NO	**Seizures**	□ YES □ NO
Bronchitis	□YES □ NO	**Herpes/Cold Sores**	□ YES □ NO	**Sinus Trouble**	□ YES □ NO
Cancer	□YES □ NO	**Hives/Rash**	□ YES □ NO	**Tonsilitis**	□ YES □ NO
Developmental Disorder	□ YES□ NO	**Kidney Disorder**	□ YES □ NO	**Trauma to face or jaw**	□ YES □ NO
Diabetes Type	□YES □ NO	**Latex Allergy**	□ YES □ NO	**Tuberculosis**	□ YES □ NO
Dizziness or Fainting	□ YES □NO	**Latex Sensitive**	□ YES □ NO	**Ulcer**	□ YES □ NO
Emotional Problems	□YES □ NO	**Liver Disorder**	□ YES □ NO	**Vertigo**	□ YES □ NO
Endocrine	□ YES □NO	**Mouth Breather**	□ YES □ NO	**Vision Impaired**	□ YES □ NO
Epilepsy	□YES □ NO	**Mitral Valve Prolapse**	□ YES □ NO	**Other:**	
Facial Jaw/TMJ Pain	□ YES □NO	**Nervous/Anxious**	□ YES □ NO		
Frequent Headaches	□ YES □NO	**Prone to colds**	□ YES □ NO		

Are there any other conditions or concerns that you think we should know about?

DENTAL HISTORY

Dentist's Name_____**Address**_____**Phone**_____

Frequency of dental checks: □ **Every**_____**months** □ **Only if problem exists** □ **Never Date of last visit**_____
Any unfinished care to be completed by dentist? □YES □ NO **Explain:**_____
Any facial or dental injuries? □ YES □ NO **Explain:**_____
Any history of thumb or finger sucking? □YES □ NO **Stopped:**_____
Does your child play a musical instrument? □YES □ NO **Which:**_____
Have teeth been removed? (primary or permanent) □YES □ NO **List:**_____
Any previous orthodontic treatment? □YES □ NO **With whom?**_____
Are you satisfied with previous treatment? □YES □ NO **Explain:**_____

Please check if there is a history of:

□ **Clenching teeth** □**Grinding teeth** □**Jaw joint clicking** □**Jaw joint soreness** □**Jaw joint popping** □**Ringing in the ears**
□**Headaches (more than normal)** □**Mouth breathing** □**Awake** □**Asleep** □**Muscular soreness around the head and neck**
Speech Problems □ **YES** □ **NO**
Explain:_____
Any other information that may be helpful?_____
Parent Signature_____**DATE**_____ **Reviewed by**_____

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Financial Responsibility

Who is financially responsible for this account? _____
Home address (or reference one above)_____
Home Phone(_____)_____ -_____ Cell#(_____)_____ -_____ Email_____
Social Security #_____Employer_____

Dental Insurance Information

Primary policy holder's full name_____ Birth date_____

Social Security #_____Relationship to patient _____

Address and phone (if not listed above)_____

Employer_____Address_____

Insurance company_____ Group #_____ID#_____

Does this policy have orthodontic benefits? O Yes O No O Don't Know

Secondary policy holder's full name_____ Birth date_____

Social Security #_____Relationship to patient _____

Address and phone (if not listed above)_____

Employer_____Address_____

Insurance company_____ Group #_____ID#_____

Does this policy have orthodontic benefits? O Yes O No O Don't Know

ORTHOSTYLE
BY DR. MINA

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Orthostyle by Dr. Mina. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for service, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility and available upon request.

Orthostyle by Dr. Mina reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY		**YES**		**NO**
SPOUSE ONLY		**YES**		**NO**
OTHER (please specify)		**YES**		**NO**

_____ _____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgment not obtained					
PROVIDED PRIOR TO TREATMENT?		**YES**		**NO**	
DATE PROVIDED:					
REASON FOR DENIAL:		NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES			
		WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING			
		UNABLE TO SIGN			
		REASON NOT GIVEN			
		OTHER (EXPLAIN):			

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