LAKEWOOD PARK ORTHODONTICS

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Name: Last First Middle In.

Address: Street City State Zip

Birthdate (MM/DD/YYYY) Preferred Pronoun:

How did you hear about our office?

RESPONSIBLE PARTY INFORMATION

Name: Last First Middle In.

Address: Street City State Zip

Home Phone Cell Phone

Relationship to Patient:

Name: Last First Middle In.

Address if different from above:

Home Phone Cell Phone

Relationship to Patient:

DENTAL INSURANCE INFORMATION

Insurance Company Phone Number

Insurance Company Address

Subscriber's Name Date of Birth

Subscriber ID # Group #

Does the patient have dual coverage? (Circle) **NO** **YES** If yes, please fill out the below:

Insurance Company Phone Number

Insurance Company Address

Subscriber's Name Date of Birth

Subscriber ID # Group #

EMERGENCY INFORMATION

Emergency Contact Name Phone No.

Address: City State Zip

Parent/Guardian Signature:____ Date:____________________

MEDICAL HISTORY

Physician ______ Date of Last Visit ______ Phone No. ______

Address: Street ______ City ______ State ______ Zip ______

Please Circle YES or NO *If YES, please fill in details*

Question			Details
Is the patient taking any medication?	NO	YES	
Is the patient allergic to any medication?	NO	YES	
Does the patient have a history of a major illness?	NO	YES	
Has the patient had any operations or hospitalization?	NO	YES	
Has the patient been involved in a serious accident?	NO	YES	
Have you seen a physician in the last 12 months?	NO	YES	
Is the patient allergic to latex?	NO	YES	
Is the patient allergic to any metals?	NO	YES	
Female Patients Only			
Has menstruation started?	NO	YES	
Is the patient pregnant?	NO	YES	

Circle any of the medical conditions below which you have had or currently have:

Abnormal Bleeding	Autism	Epilepsy/seizures	Hearing Loss	Frequent headaches
ADD/ADHD	Tuberculosis (TB)	Fever Blisters/Herpes	Kidney Problems	Sinus Problem
Anemia	Radiation/Chemotherapy	Heart Murmur	Obstructive Sleep Apnea	Gastrointestinal issues
Arthritis	Congenital Heart Defect	Hemophilia	Dental Anxiety	Snoring
Artificial Bone/Joint/Valve	Diabetes	Hepatitis	Radiation Treatment	Bone Disorders
Asthma	Difficulty Breathing	HIV+/AIDS	Rheumatic/Scarlet Fever	

Are there any medical conditions not listed of which you feel we should be aware?

______

DENTAL HISTORY

General Dentist ______ Date of Last Visit ______ Phone No. ______

Address: Street ______ City ______ State ______ Zip ______

What is the main concern with the patient's teeth? ______

Please Circle YES or NO *If YES, please fill in details*

Question			Details
Is the patient presently in any dental pain?	NO	YES	
Has the patient ever lost or chipped any teeth?	NO	YES	
Have there ever been any injuries to face, mouth, or teeth?	NO	YES	
Is the patient's mouth sensitive to temperature/pressure?	NO	YES	Where?
Do the patient's gums bleed when brushing?	NO	YES	
Does the patient have any type of thumb or tongue habit?	NO	YES	
Is the patient a mouth breather or do they snore?	NO	YES	
Has the patient ever seen an orthodontist?	NO	YES	Who and when?
What is the patient's attitude toward receiving orthodontic treatment?			
Has anyone in the family received orthodontic treatment?	NO	YES	
Do the patient's teeth or jaws ever feel uncomfortable first thing in the morning?	NO	YES	
Does the patient experience jaw clicking or popping?	NO	YES	
Does the patient clench or grind his/her teeth during the day?	NO	YES	
Has the patient ever experienced chronic ringing in the ears?	NO	YES	
Are you aware that some appointments will be during school hours?	NO	YES	

SOME BENEFITS AND RISKS OF ORTHODONTIC TREATMENT

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize **Dr. Hughes** to perform a complete orthodontic evaluation. If orthodontic treatment commences, a more thorough informed consent will be provided.

Parent/Guardian Signature:______________________________ Date:__________ Dr.'s Initials______

LAKEWOOD PARK
ORTHODONTICS

Help us get to know you better !

My name is ______________________, and my nickname is_________________.

I am ________ years old and in _________ grade at______________________school.

My favorite subject is ______________. My pets are___________________________.

My brothers and sisters are____.

My hobbies are______________________ and ________________________.

My favorite kind of music is______________ .

Do you feel that your teeth are (circle all responses):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Off color?	No	Yes

Do you feel your front teeth 'stick out too much' ("Buck Teeth")?	No	Yes
Are there spaces between your teeth that you do not like?	No	Yes
Is there too much or too little gum tissue showing when you smile?	No	Yes
Have you had previous orthodontic treatment?	No	Yes

Are there other dental issues not listed above that you would like to discuss or have treated?
No Yes (please explain)______________________________________

We look forward to meeting you !

From Dr. Hughes and the Lakewood Park Orthodontics Staff

190 N. Main St Suite 101, Natick MA 01760 Telephone# 508-319-1545
www.lakewoodparkorthodontics.com

Electronic Communication Consent

Patient Name: _______________________________________ Date of Birth:_______________

I agree that Lakewood Park Orthodontics may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: 508-319-1545

Patient/Guardian Email Address (PLEASE PRINT CLEARLY):

____@__________________________

Signature:____

Date:_________________________

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. **This material is for general reference purposes only and does not constitute legal advice. It covers only HIPAA , not other federal or state law. Changes in applicable laws or regulations may require revision. Dentists should contact qualified legal counsel for legal advice, including advice pertaining to HIPAA compliance, the HITEC H Act, and the U.S. Department of Health and Human Services rules and regulations.**

© 2010, 2013 American Dental Association. All Rights Reserved.

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

Date:____

For Office Use Only

____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. **This material is for general reference purposes only and does not constitute legal advice. It covers only HIPAA, not other federal or state law. Changes in applicable laws or regulations may require revision. Dentists should contact qualified legal counsel for legal advice, including advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.**

© 2010, 2013 American Dental Association. All Rights Reserved.