Scott & Jane
ORTHODONTICS

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birthdate _____ Social Security # _____

School _____ Sports/Hobbies _____

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

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Address _____
Street City Zip

Home phone _____ Work phone _____ Cell/other phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer_____ Occupation _____

Email Address_____

Spouse's Name _____ Relationship to Patient _____

Spouse's Social Security # _____ Spouse's Birthdate _____ Work Phone _____

Spouse's Employer_____ Occupation_____

DENTAL INSURANCE INFORMATION

Subscriber's Name_____ Member ID or SSN # _____

Subscriber Date of Birth _____ Group No. _____

Insurance Company_____Phone No. _____

Insurance Co. Address _____ Do you have dual coverage? Yes_____ No_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone_____ Relationship to Patient _____

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DENTAL HISTORY

Why is your child seeking orthodontic treatment? (Please be as specific as possible) _____

_____

General Dentist _____ Date of last visit _____

Yes	No	Is the patient presently in any dental pain?
Yes	No	Have there been any injuries to face, mouth, or teeth? _____
Yes	No	Any type of thumb or tongue habit? _____
Yes	No	Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes	No	What is the patient's attitude toward receiving orthodontic treatment? _____
Yes	No	Has anyone in the family received orthodontic treatment? _____
		How did they feel about the result? _____
Yes	No	Experience jaw clicking or popping? _____
Yes	No	Experience "tension" headaches? _____
Yes	No	Is the patient sensitive or self-conscious about his/her teeth? _____
Yes	No	Are you aware that some appointments will be during school hours? _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes	No	Is the patient taking any medication? _____
Yes	No	Is the patient allergic to any medication? _____
Yes	No	History of a major illness? _____
Yes	No	Ever been involved in a serious accident? _____
Yes	No	Has the patient had any operations? _____
Yes	No	Have the patient seen a physician in the last 12 months? Why? _____
Yes	No	Is the patient pregnant? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

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. Scott Huang or Dr. Jane Lu to perform a complete orthodontic evaluation.

Signature:_____Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

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.

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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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:

Contact Person: Office Manager
Telephone: 832-539-6388
E-mail: info@scottandjane.com
Address: 5418 Highway 6, Suite 215, Missouri City, TX 77459

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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 health care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.