CHILD - ADULT PATIENT INFORMATION & MEDICAL HISTORY

A B C

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Houston, TX 77005
(713) 481-4885
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PATIENT INFORMATION

Date	Patient's Last name	First name	Middle name
Address	Street	City	ZIP

Home Phone	Birthdate	Social Security #

If patient is a minor, give parent's or guardian's name	
Whom may we thank for referring you to our office?	

RESPONSIBLE PARTY INFORMATION

Name	Last name	First name	Middle name
Residence	Street	City	ZIP
Mailing Address	Street	City	ZIP

How long at this address?	Home phone	Work phone	Cell/other phone

Email address	Social Media	Facebook	Instagram	Twitter

Previous Address (If less than 3 years)	

Social Security #	Birthdate	Relationship to Patient
Employer	Occupation	No. years employed

Spouse's Name	Relationship to Patient

Employer	Occupation	No. years employed
Social Security #	Birthdate	Work phone

DENTAL INSURANCE INFORMATION

Insured's Name	Insured's Social Security #

Insurance Company	Group N°	Local N°
Insurance Co. Address		Phone N°

Do you have dual coverage?	Yes	No	If yes:

Insured's Name	Insured's Social Security #

Insurance Company	Group N°	Local N°
Insurance Co. Address		Phone N°

EMERGENCY INFORMATION

Name of nearest relative not living with you			
Complete Address	Street	City	ZIP
Phone			

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

Signature (Parent's signature if minor)	
Updates (date & initial)	

MEDICAL HISTORY

Physician	Date of Last Visit	Address	Phone

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

Yes	No	Are you taking any medication?
Yes	No	Are you allergic to any medication?
Yes	No	Do you have a history of a major illness?
Yes	No	Have you had any operations?
Yes	No	Have you ever been involved in a serious accident?
Yes	No	Have seen a physician in the last 12 months? Why?

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

	Abnormal bleeding/Hemophilia		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?

DENTAL HISTORY

General Dentist	Date of Last Visit	What concerns you most about your teeth?

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

Yes	No	Are you presently in any dental pain?				
Yes	No	Have you ever experienced any unfavorable reaction to dentistry?				
Yes	No	Have you ever lost or chipped any teeth?				
Yes	No	Have there been any injuries to face, mouth, or teeth?				
Yes	No	Is any part of your mouth sensitive to temperature? Where?				
Yes	No	Is any part of your mouth sensitive to pressure? Where?				
Yes	No	Do your gums bleed when you brush?				
Yes	No	Do you have any type of thumb or tongue habit?				
Yes	No	Are you a mouth breather?				
Yes	No	Have you ever seen an orthodontist? If yes, who and when?				
Yes	No	What is your attitude toward receiving orthodontic treatment?				
Yes	No	Has anyone in your family received orthodontic treatment?				
		How did they feel about the result?				
Yes	No	Do your teeth or jaws ever feel uncomfortable when you awake in the morning?				
Yes	No	Are you aware of your jaw clicking or popping?				
Yes	No	Are you aware of clenching your teeth during the day?				
Yes	No	Have you ever been told that you grind your teeth?				
Yes	No	Do you have “tension” headaches?				
Yes	No	Have you ever experienced chronic ringing in your ears?				
Yes	No	If the patient is under age 16, height of parents?	Mom		Dad	
Yes	No	Are you aware that some appointments will be during school/work hours?				
		Please list some hobbies or interests				
		Female Patients only:				
Yes	No	Are you pregnant?				
Yes	No	Has menstruation started?				

BENEFITS

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 also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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.		to perform a complete orthodontic evaluation.

Signature:		Date:	

CONSENT FOR USE AND DICLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT			
Name:			
Address:			
Telephone:		Email address:	
Patient Number:		Social Security Number:	

SECTION B: TO PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 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: Dr. Anna Maria Salas
Telephone: (713)481-4885 Fax: (713)481-4886
E-mail: drsalas@westuortho.com
Address: 3642 University Blvd., Suite 102. Houston, TX 77005

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:	