# CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM FOR PATIENTS UNDER 21

## PATIENT INFORMATION

**Patient's Name:** _____ I prefer to be Called: _____ Date: _____
DOB: _____/_____/_____ Age: _____ Weight: _____ Height: _____ Sex: M/F
Patient's Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone No.: _____ Cell Phone No.: _____ Attends School at: _____
Sports, Hobbies, And/or Interests: _____
Other family members treated here: _____ How did you first learn about our office?_____
Who suggested that your child might need orthodontic treatment? _____
Name of Dentist: _____ Last seen: _____ Reason: _____
Name of Physician(s): _____ Last seen: _____ Reason: _____

## RESPONSIBLE PARTY INFORMATION

**Who's with you today?** _____**Relation:**_____
**Mother/Guardian's Name:** _____ DOB: _____/_____/_____ SS#: _____
Address (if different than patient's): _____ City: _____ State: _____ Zip Code: _____
Phone No. (if different than patient's): Home:_____ Work No.: _____ Cell No.: _____
**Father/Guardian's Name:** _____ DOB: _____/_____/_____ SS#: _____
Address (if different than patient's): _____ City: _____ State: _____ Zip Code: _____
Phone No. (if different than patient's): Home:_____ Work No.: _____ Cell No.: _____
**Email Address:** _____
**Marital Status of Parents/Guardian:** ☐**Single** ☐**Married** ☐**Divorced** ☐**Separated**

## DENTAL INSURANCE INFORMATION

**Primary** Policy Holder's Name: _____SS#: _____ ID#: _____ DOB: ____/____/____
Insurance Company: _____ Phone No: _____
Employer's Name:_____ Group # :_____
**Secondary** Policy Holder's Name: _____SS#: _____ ID#: _____ DOB: ____/____/____
Insurance Company: _____ Phone No: _____
Employer's Name:_____ Group # :_____

## DENTAL HISTORY Now or in the past, has the patient had:

☐**yes** ☐**no** Any teeth removed for any reason?
☐**yes** ☐**no** Supernumerary (extra) or congenitally missing teeth?
☐**yes** ☐**no** Chipped or injured primary (baby) or permanent teeth?
☐**yes** ☐**no** Teeth sensitive to hot or cold; teeth throb or ache?
☐**yes** ☐**no** Jaw fractures. Cysts or mouth infections?
☐**yes** ☐**no** "Dead teeth" or root canals treated?
☐**yes** ☐**no** Periodontal problems, bleeding gums, bad taste or odor?
☐**yes** ☐**no** Thumb, finger, or sucking habit? Until what age _____?
☐**yes** ☐**no** Abnormal swallowing habit (tongue thrusting)?
☐**yes** ☐**no** History of speech problems?
☐**yes** ☐**no** Mouth breathing habit, snoring or difficulty in breathing?
☐**yes** ☐**no** Tooth grinding, jaw clenching clicking or locking?
☐**yes** ☐**no** Any pain in jaw or ringing in the ears?

☐**yes** ☐**no** Difficulty encountered in chewing or jaw opening?
☐**yes** ☐**no** Have you ever been treated for "TMD" or "TMJ" problems?
☐**yes** ☐**no** Aware of loose, broken or missing restorations (fillings)
☐**yes** ☐**no** Any teeth irritating cheek, lip, tongue or palate?
☐**yes** ☐**no** Frequent canker sores or cold sores?
☐**yes** ☐**no** Any wisdom tooth problems?
☐**yes** ☐**no** Is patient sensitive or self-conscious about teeth?
☐**yes** ☐**no** Ever had a prior orthodontic examination or treatment?
How often does your child brush? _____ Floss?_____
Does your child want braces? ☐**yes** ☐**no**
What does your child want to change about their teeth? _____
What concerns you most about your child's teeth? _____
_____

**MEDICAL HISTORY** **Now or in the past, has the patient had:**

- ☐yes ☐no Birth defects or hereditary problems?
- ☐yes ☐no Bone fractures, any major accidents?
- ☐yes ☐no Rheumatoid or arthritic conditions?
- ☐yes ☐no Endocrine or thyroid problems?
- ☐yes ☐no Kidney problems?
- ☐yes ☐no Diabetes?
- ☐yes ☐no Cancer, tumor, radiation treatment or chemotherapy?
- ☐yes ☐no Stomach ulcer or hyperacidity?
- ☐yes ☐no Polio, mononucleosis, tuberculosis, or pneumonia?
- ☐yes ☐no Problems of the immune systems? AIDS or HIV positive?
- ☐yes ☐no Hepatitis, jaundice or liver problem?
- ☐yes ☐no Fainting spells, seizures, epilepsy or neurological problem?
- ☐yes ☐no Mental health disturbance or behavioral problem?
- ☐yes ☐no Vision, hearing, tasting or speech difficulties?
- ☐yes ☐no Loss of weight recently, poor appetite?
- ☐yes ☐no History of eating disorder (anorexia, bulimia)?
- ☐yes ☐no Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ☐yes ☐no High or low blood pressure?
- ☐yes ☐no Chest pain, shortness of breath or swelling ankles?
- ☐yes ☐no Cardiovascular problem (heart trouble, heart attack, angina coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- ☐yes ☐no Skin disorder?
- ☐yes ☐no Does the patient eat a well-balanced diet?
- ☐yes ☐no Frequent headaches, colds or sore throat?
- ☐yes ☐no Eye, ear, nose or throat conditions?
- ☐yes ☐no Hay fever, asthma, sinus trouble or hives?
- ☐yes ☐no Tonsil or adenoid conditions?

**Circle allergies or reactions to any of the following:**

| | |
|---|---|
| Local anesthetics (Novocaine) | Codeine or other narcotics |
| Aspirin | Ibuprofen (Motrin, Advil) |
| Penicillin or other antibiotics | Sulfa Drugs |
| Metals (jewelry) | Latex (gloves, balloons) |
| Vinyl, acrylic, or animals | Foods (specify):_____ |
| | None |

**Please list any** medication, nutrient supplements, herbal medications or non-prescription medicine being taken by the patient.

Medication _____Taken for_____

Medication _____Taken for_____

Medication _____Taken for_____

- ☐yes ☐no Current or past substance abuse problem?
- ☐yes ☐no Does the patient chew or smoke tobacco?
- ☐yes ☐no Operation or Surgery? Describe: _____
- ☐yes ☐no Hospitalized? For: _____
- ☐yes ☐no Being treated by another health care professional? For: _____
- ☐yes ☐no Are there any other medical conditions that we should be aware of? Specify: _____

_____

**GIRLS ONLY**

- ☐yes ☐no Has the patient started her monthly periods? If so, approximately when? _____
- ☐yes ☐no Is the patient pregnant?

**FAMILY MEDICAL HISTORY**

List any family medical conditions that we should know about?

_____

_____

**RELEASE AND WAIVER**

I hereby authorize release of any information related to insurance claims and authorize payment of any insurance benefits to Trieu Smiles LLC. Further more, I consent to treatment and authorize the dental staff to perform the necessary dental services I may need during treatment. I have read and understand the above questions. I will not hold my orthodontist or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Parent/Guardian)

Signed: _____ Date Signed: _____
(Dental Staff Member)

Trieu Smiles ORTHODONTICS
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# NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

## Uses and disclosures of health information

We use and disclose health information about you for treatment, payment and healthcare operations. Your protected health information (i.e., individually identifiable information, such as medical and dental histories, names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- Treatment- To other health care providers (i.e., your physician, general dentist, oral surgeon, periodontist, etc.) in connection with our rendering orthodontic treatment to you;
- Payment-To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment for services we provide to you (i.e. to determine benefits, dates of payment, etc.); Insurance claims may be sent electronically;
- Healthcare Operations-To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontists, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders (such as email, voicemail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- There are additional situations when we are required to use or disclose your protected health information without your consent or authorization (i.e. reporting to law enforcement officials, government agencies, Judicial and Administrative Proceedings, for public health activities, research, workers compensations, or to avoid a serious threat to health or safety).

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

**Patient rights -** Under the new privacy rules, you have the right to:

- Request restrictions (in writing) on the use and disclosure of your protected health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency)
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your health information through asking us;

- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information. This accounting will not include disclosures of health information that we made for purposes of treatment, payment or health care operations pursuant to a written authorization that you have signed.
- You may, without the risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States of Health and Human Services (which must be filed within 180 days of the violation).

**Our legal duty** - We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature on the acknowledgement of receipt of this notice. If you have any questions about the information in this notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

**PATIENT ACKNOWLEDGMENT**

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____

Signature of Patient/Authorized Representative Date

_____

Relationship to Patient

_____

Please print name

If unable to sign please state reason:

_____

_____