kirkland ORTHODONTICS

Today's Date: _____
MM/DD/YYYY

PATIENT

Patient's Last Name_____First Name_____
Preferred Name_____ Date of Birth _____
MM / DD / YYYY
Email _____
Cell Phone_____Provider (used for text messaging reminders)_____
Home Address_____
STREET CITY STATE ZIP
How did you hear about our office?_____
If referred by a patient/friend, whom may we thank?_____

GENERAL INFORMATION

Have you ever had orthodontic treatment before? If so, when?_____
What concerns do you have about your teeth?_____
Do you like your smile? ☐ Yes ☐ No
How do you feel about Orthodontic Treatment?_____
Have any other family members had Orthodontic Treatment? _____
Have you had a previous orthodontic consultation? _____
If yes, what was the reason for not starting treatment?_____
Your favorite hobbies and activities_____

DENTIST

Patient's Dentist_____City, State_____, _____
Last Appointment_____Reason_____Next Appointment_____
Other dental specialists being seen_____Last Appointment_____
Reason_____

EMERGENCY CONTACT

Last Name_____ First Name_____
Relationship to Patient_____
Home Address_____
STREET CITY STATE ZIP
Cell Phone_____Email_____

OTHER INVOLVED PARTIES

List anyone else who will be involved in your care or is financially responsible
Name_____Relationship to Patient_____
Home Address_____
STREET CITY STATE ZIP
Cell Phone_____Email_____
Financially Responsible ☐ Yes ☐ No

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DENTAL INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No ☐ Unsure

Primary Insurance Co._____

Employer_____

Primary Policy Holder_____ Date of Birth _____
MM / DD / YYYY

ID#_____ Group #_____

Secondary Insurance Company_____ Employer_____

Policy Holder_____ Date of Birth _____
MM / DD / YYYY

ID#_____ Group #_____

DENTAL HISTORY

Have you been informed of missing or having extra permanent teeth? ☐ Yes ☐ No

Chipped or Injured primary or permanent teeth ☐ Yes ☐ No

Injuries to the: ☐ Face ☐ Mouth ☐ Chin

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Now, or in the past, had any of the following:

Lip/thumbsucking	☐	Tongue thrust	☐	Pain in jaw joint	☐
Difficulty closing lips	☐	Mouth breather	☐	Grind teeth	☐
Snoring	☐	Sleep apnea	☐	Clench teeth/jaw	☐

MEDICAL HISTORY

Has the patient had and/or have any of the following:

Tonsils removed	☐	Snoring	☐	Herpes	☐	Joint replacement or implant	☐
Adenoids removed	☐	ADD/ADHD	☐	AIDS, HIV positive	☐	Heart defect, disease or murmur	☐
Sleep apnea	☐	Latex allergy	☐	Hepatitis	☐	Fainting spells, seizures	☐
Asthma	☐	Nickel allergy	☐	Diabetes	☐	Scarlet fever, rheumatic fever	☐
Stroke	☐	Excessive Bleeding	☐	High/low blood pressure	☐	Drug/alcohol dependency	☐

List any known allergies_____

Are you taking any medications?_____ If yes, please list_____

Do you take any antibiotic pre-medication before any dental procedures?_____

Are you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa?_____ If so, which drug? _____

If female, are you pregnant?_____ Do you smoke cigarettes/chew tobacco? ☐ Yes ☐ No

Any other disease, condition or problem not listed that you think we should know about?

_____

Do you require pre-med antibiotics prior to dental visits? ☐ Yes ☐ No

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes made in my medical or dental health. I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Patient Electronic Signature _____

Date _____

AUTHORIZATION AND CONSENT TO SEND UNENCRYPTED PATIENT INFORMATION AND OTHER ELECTRONIC MEANS

I authorize Kirkland Orthodontics to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for treatment, or Kirkland Orthodontics health care operations. The patient information may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- *I do not have to sign this form.*
- *My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.*
- *If I don't sign this form, Kirkland Orthodontics may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.*
- *Kirkland Orthodontics does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.*

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Kirkland Orthodontics already sent before receiving my written instructions to stop.

Patient Electronic Signature _____

Date _____

MM / DD / YYYY