

8266 Jupiter Drive Mechanicsville, VA 23116 Phone: 804.746.7720

Fax: 804.200.4349

www.alohabraces.us

## Patient Information — Child

All About Your Child	Has your child ever had or been evaluated for orthodontic			
Name:	treatment? Y N Have there ever been any injuries to the face, mouth, teeth or chin? Y N Does your child brush his/her teeth daily? Y N Floss his/her teeth daily? Y N Has puberty begun? Y N Has menstruation begun? (Girls) Y N			
Last First MI				
Nickname:				
Male/ Female				
School:Grade:				
Hobbies/Sports:				
Child's Home: # ( )				
Child's Home Address:	Does your child now have or ever experienced pain or			
City:State:Zip:	discomfort in their jaw joint (TMJ/TMD)? Y N			
Who is Asserted with Very Obild Today?	Child's Physician:			
Who is Accompanying Your Child Today?	Phone: #( )			
Name:Relation:	Is your child currently under the care of a physician? Y N			
Do you have legal custody of this child? Y N	Please list all drugs your child is currently taking:			
Whom may we thank for referring you? Other family members seen by us?	Please all drugs/things your child is allergic to:			
	Please indicate whether your child has ever had any of the following			
Dentist	medical problems:			
General Dentist:	Abnormal Bleeding Y N Allergies to any drugs Y N			
Date of Last Exam:	Allergic to Latex/Metals Y N Allergic to plastic Y N			
	Asthma Y N Cancer Y N			
Mother Stepmother Guardian	Congenital Heart Defects Y N Convulsions/Epilepsy Y N			
Name:	Diabetes Y N Handicaps/Disabilities Y N			
Last First	Hearing Impairment Y N Heart Murmur Y N			
Birthdate:/	Hemophilia Y N Hepatitis Y N			
Employer:	HIV+/AIDS Y N Hospitalization Y N			
Work: # ( ) Cell: # ( )	Kidney/Liver Problems Y N Operations Y N			
Email:	Rheumatic/Scarlet Fever Y N Tuberculosis Y N			
Follow Overfall and Overfall	Please list any medical problems that your child has had:			
Father Stepfather Guardian  Name:				
Last First	Has your child ever had any of the following habits?			
Birthdate:/	Clenching/Grinding Y N Lip Sucking/Biting Y N			
Employer:	Nail Biting Y N Tongue Thrusting Y N			
Employer: Work: # ( ) Cell: # ( )	Mouth Breathing Y N Thumb/Finger Sucking Y N			
Email:	Soda Pop Drinker Y N			
	I understand that the information I have provided is correct to the best of my			
Who will be responsible for making appointments?:	knowledge and that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I			
Who will be responsible for the account?	authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.			
What are your main concerns that you would like orthodontics to accomplish?				
	Signature of Parent/Guardian Date			



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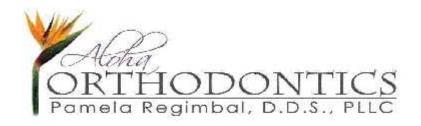
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### **Account & Insurance Information**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

RESPO	NSIBLE PARTY
Name:	CC#.
	SS#:
Billing Address:	
·	State: Zip:
Home #: ( )	Email:
Employer:	Work #: ( )
PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Policy Holder:	Policy Holder:
Relation:	Relation:
Address:	
City: State: Zip:	
Home #: ( ) Cell #: ( )	Home #: ( ) Cell #: ( )
SS#: Birthdate:	SS#: Birthdate:
Employer:	Employer:
Employer Address:	Employer Address:
City: State: Zip:	
Work #: ( ) Ext:	
Insurance Company:	Insurance Company:
Insurance Co. Address:	
City: State: Zip:	
Group #:	
Plan #:	
Subscriber ID #:	
Phone #:	



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#### **Patient Consent Form**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- ) Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this	day of	, 20
Print Patient Name:		
Relationship to Patient:		
Signature:		



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## Permission To Discuss Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

named patient:	Name:		formation about the care of the ab
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		OR	
This authorization pe	rmits Aloha Orthodontics to about myself/or my child. It	use and/or disclo	nild's protected information to anyone the following individually identifulation Aloha Orthodontics will only disclarment.
			e:



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# What's Most Important to You?

We consider your satisfaction to be of the utmost importance, and this starts by personalizing your orthodontic experience. Please review the treatment aspects below that our skilled team of professionals can deliver using several state-of-the-art technologies.

#### (Please rank your top three treatment aspects from 1 to 3)

Aesthetics: I would prefer it if people don't notice that I'm in orthodontic treatment.
Colors: I want to have fun displaying different colors (on holidays, for sports teams, etc.).
Comfort: I want the highest degree of comfort possible during treatment.
Length of time in Treatment: I want to have a beautiful smile as quickly as possible.
Visit Frequency: I want to come to the orthodontist as few times as possible.
Appointment Length: I want to sit in the chair for short periods during adjustment appointments.
Schedule: I'd like appointments to accommodate my own schedule (before or after school/work).
Punctuality: I want to be seen on time for adjustment appointments.
Treatment Cost: The down payment and monthly payment are major considerations.
Other: