WINNING ORTHODONTIC SMILES

THE PATIENT

Today's Date_____

Name:_____
(Mr./Mrs/Sgt/Col/Dr/Rev,etc) Last Name First Name MI What would you prefer that we call you

Birthdate:_____/_____/_____ Age:_____ Sex: M ( ) F ( )

Home Phone:(____)_____Cell Phone:(____)_____

E-Mail Address:_____

Home Address:_____

Mailing Address:_____

City:_____State_____Zip_____ Social Security#:_____

Check Appropriate Box: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Employer:_____Business Phone: (____)_____

Spouse's Name:( )_____Cell Phone:(____)_____
(Mr/Mrs/Sgt/Col/Dr/Rev, etc)

Employer:_____Business Phone: (____)_____

Family Dentist:_____Referred By:_____

Date of Last Dental Exam/Cleaning:_____

Any dental care recommended, but not completed?_____

List Family Members Seen by Dr. Burris:_____

What Is Your Chief Concern? Tooth alignment_____bite_____TMJ____ other_____

Facial Concerns? Chin_____Lips_____Nose_____Eyes/Eyelids_____Ears_____

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

☐ yes ☐ no ☐ dk/u Permanent or "extra" (supernumerary) teeth removed?
☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
☐ yes ☐ no ☐ dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts or mouth infections?
☐ yes ☐ no ☐ dk/u "Dead teeth" or root canals treated?
☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or mouth odor?
☐ yes ☐ no ☐ dk/u Periodontal "gum problems"?
☐ yes ☐ no ☐ dk/u Food impaction between teeth?
☐ yes ☐ no ☐ dk/u "Gum boils", frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u Thumb, finger, or sucking habit? Until what age_____?
☐ yes ☐ no ☐ dk/u Abnormal swallowing habit (tongue thrusting)?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Mouth breathing habit, snoring or difficulty breathing?
☐ yes ☐ no ☐ dk/u Tooth grinding or jaw clenching?
☐ yes ☐ no ☐ dk/u Any pain, clicking or locking in jaw or ringing in the ears?
☐ yes ☐ no ☐ dk/u Any pain or soreness in the muscles of the face or around the ears?
☐ yes ☐ no ☐ dk/u Difficulty in chewing or jaw opening?
☐ yes ☐ no ☐ dk/u Have you ever been treated for "TMD" or "TMJ" problems?
☐ yes ☐ no ☐ dk/u Aware of loose, broken or missing restorations (fillings)?
☐ yes ☐ no ☐ dk/u Any teeth irritating cheek, lip, tongue or palate?
☐ yes ☐ no ☐ dk/u Concerned about spaced, crooked or protruding teeth?
☐ yes ☐ no ☐ dk/u Aware or concerned about under or over developed jaw?
☐ yes ☐ no ☐ dk/u Any relative with similar tooth or jaw relationships?
☐ yes ☐ no ☐ dk/u Any wisdom tooth problems?
☐ yes ☐ no ☐ dk/u Had periodontal (gum) treatment?
☐ yes ☐ no ☐ dk/u Had any serious trouble associated with any previous dental treatment?
☐ yes ☐ no ☐ dk/u Been under another dentist's care?
_____Specialist
_____Other
☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination or treatment?
☐ yes ☐ no ☐ dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

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MEDICAL HISTORY:

Are you currently under the care of a Physician? ( )yes ( )no
If yes, explain:_____

Are you currently taking any medications? ( )yes ( )no
If yes, explain:_____

Do you have any allergic reactions or allergies? ( ) yes ( ) no
If yes, list:_____

Do you have or have you had in the past any of the following:

( ) Heart Murmur	( ) Psychiatric Problems	( ) Hearing Problems
( ) Any Heart Problem	( ) High or Low Blood Pressure	( ) Speech Impediment
( ) Mitral Valve Prolapse	( ) Diabetes	( ) Epilepsy/Seizures
( ) Kidney or Liver Problems	( ) Tuberculosis	( ) Anemia
( ) Rheumatic Fever	( ) Hemophilia	( ) Asthma
( ) Hepatitis	( ) HIV/AIDS	( ) Other

WOMEN ONLY:

Are you pregnant? ( ) yes ( ) no Do you plan on becoming pregnant? ( ) yes ( ) no

Physician:_____

Person to Contact in Case of Emergency: (outside household)

Name_____Home#_____Work#_____

I HEREBY CONSENT TO THE ORTHODONTIC EXAMINATION PROVIDED BY DR. BURRIS/DR. FIEGLE.

SIGNATURE:_____DATE:_____

ORTHODONTIC INSURANCE

Primary Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co.Phone#:_____Group#_____
Insured's Name:_____Relation:_____
Insured's Birthday:_____/_____/_____S.S.#_____
Insured's Employer:_____
Secondary Insurance:_____

PAYMENT DUE AT TIME OF SERVICE

I understand and agree that I am responsible for payment. I certify this information is true and correct to the best of my knowledge.

Signature_____Date_____

In addition, when appropriate, a credit report may be obtained

Signature_____Date_____

I AUTHORIZE DR. BURRIS/DR. FIEGLE TO OBTAIN OR PROVIDE MEDICAL HISTORY OR OTHER INFORMATION RELATED TO ORTHODONTIC TREATMENT FROM OR TO OTHER HEALTH CARE PROVIDERS.

SIGNATURE:_____DATE_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

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843-525-6228 843-524-4468
winningsmilesbeaufort@gmail.com

Winning Orthodontic Smiles

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843-836-3010 843-836-3014
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For good and valuable consideration and by signing this release, I do hereby give Winning Orthodontic Smiles, their assigns, licensees and legal representatives the irrevocable right to use my image in all legal forms and media and in all legal manners, for advertising, trade or any other lawful purposes. I waive any rights to inspect or approve the finished product, including written copy that may be created in connection theirwith.

I have read this release and fully understand its contents.

Name _____

Address _____

City _____ State _____ Zip Code _____

Country _____ USA _____

Age _____ * *If under 18, fill out CONSENT section below.*

Contact Information

Phone Number _____
and/or
Email _____

Signature _____

Date _____

CONSENT

(If model is under the age of 18) I am the parent or guardian of the minor named above and I have the legal authority execute the above release. I approve the foregoing.

Name _____

Address _____

City _____ State _____ Zip Code _____

Country _____

Signature _____

Date _____

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PATIENT NAME: _____

I hereby consent Winning Orthodontics Smiles to complete the following:

1) Initial photographs and digital xrays

2) Examination of teeth for future orthodontic treatment

3) Scan finger for automatic check-in: Yes___ No___

Signature:_____ Date:_____

Print name if other than patient:_____

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