WINNING ORTHODONTIC SMILES

THE PATIENT Today's Date _____

Name: _____
Last Name First Name MI What is patients preferred Name

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

Interest and Hobbies: _____
If Patient is a Student, Name of School/College_____Grade_____

Family Dentist:_____Referred By:_____
Date of last dental exam/cleaning: _____
Any dental care recommended, but not completed?_____
List Family Members seen by us: _____
What is patient's chief concern? Tooth alignment_____Bite_____TMJ_____Other_____
Facial Concerns? Chin_____Lips_____Nose_____Eyes/Eyelids_____Ears_____

THE PARENT'S ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Other:

Father's Name (_____) _____
(Mr./Col/Sgt/Dr/Rev, etc) Last Name First Name MI
Mailing Address_____Home Phone_____
City_____State_____Zip_____Cell Phone _____
Employer: _____Work Phone_____

Mother's Name (_____) _____
(Mrs/Ms/Col/Sgt/Dr/Rev, etc) Last Name First Name MI
Mailing Address_____ _____Home Phone_____
City_____State_____Zip_____Cell Phone _____
Employer:_____Work Phone_____
E-Mail Address: _____

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

☐ yes ☐ no ☐ dk/u Started teething very early or late?
☐ yes ☐ no ☐ dk/u Primary (baby) teeth removed that were not loose?
☐ 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 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 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 encountered in chewing or jaw opening?
☐ 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 "Gum boils", frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u Taking any forms of fluoride?
☐ yes ☐ no ☐ dk/u Any relative with similar tooth or jaw relationships?
☐ yes ☐ no ☐ dk/u Had periodontal (gum) treatment?
☐ yes ☐ no ☐ dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?
☐ yes ☐ no ☐ dk/u Any serious trouble associated with any previous dental treatment?
☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination or treatment?
☐ yes ☐ no ☐ dk/u Been under another dentist's care?

Specialist_____
Other_____

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MEDICAL HISTORY:

Is the patient currently under the care of a Physician? ( ) yes ( ) no

If yes, explain:_____

Is the patient currently taking any medications? ( ) yes ( ) no

If yes, explain:_____

Does the patient have any allergic reactions or allergies? _____List_____

Physician:_____

Has patient had any history of?

( ) 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	( ) Hyperactivity

( ) Other_____

GIRLS ONLY: Has patient started her monthly periods? _____If Yes When_____

Is the patient pregnant? _____

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

Name_____Home#_____Work#_____

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

_____

Signature of Person Legally Responsible for Child & Account **Date**

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

SIGNATURE:_____

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: _____

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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 _____

960 Ribaut Road, Suite 2, Beaufort, SC 29902
843-525-6228 843-524-4468
winningsmilesbeaufort@gmail.com

Winning Orthodontic Smiles

102 Buckwalter Parkway, Unit 3J, Bluffton, SC 29910
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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Name:_____

Tell us about yourself!

What five words best describe you?

What would you do with one million dollars?

What do you want to be when you grow up?

What do you like to do when you aren't in school?

If you could grow up to be famous, what would you be famous for?

What is the best gift you have ever received?

If you could meet anybody in person, who would you pick?