LIBERTY HILL ORTHODONTICS

**Patient Information**

Patient Name: _____
Nickname: _____ Date of Birth: _____
Social Security Number: _____ Gender: _____
Address: _____ Home Phone: _____
City, State, Zip code: _____ Work Phone: _____
Email address: _____ Mobile Phone: _____
How would you like us to confirm future appointments? Choose one or both and enter information:
□ Email: _____ □ Text: _____

**General Information**

Who can we thank for your referral? _____
What don't you like about your smile? _____
What are the patient's hobbies/interests? _____

**Dentist/Physician information**

Dentist Name: _____ Dentist Phone: _____
Last cleaning date: _____
Physician Name: _____ Physician Phone: _____
Is the patient currently under the care of a physician? □ Yes □ No
If yes, please explain _____

**Parent Information (If patient is a minor) and Insurance Information**

Father's Name: _____ Social Security number: _____
Address _____ Date of Birth: _____
City, State, Zip code: _____ Home phone: _____
Email address: _____ Work phone: _____
Employer: _____ Mobile phone: _____
Insurance company: _____ Insurance phone number: _____
Insurance address: _____ Insurance group number: _____
Insurance city, state, zip: _____ Insurance ID number: _____
Spouse's Name: _____

Mother's Name: _____ Social Security number: _____
Address: _____ Date of Birth: _____
City, State, Zip code: _____ Home phone: _____
Email address: _____ Work phone: _____
Employer: _____ Mobile phone: _____
Insurance company: _____ Insurance phone number: _____
Insurance address: _____ Insurance group number: _____
Insurance city, state, zip: _____ Insurance ID number: _____
Spouse's Name: _____

**Siblings' Names and Ages:**

_____
_____
_____

Parent/Guardian name: _____ Date: _____
Signature: _____
Relationship to patient: _____

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**Patient's Dental/Medical History** (Please complete all questions. Write additional information if necessary.)

Please check the main concerns below:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Crowding | ☐ Overbite | ☐ Protrusion of teeth | ☐ Misalignment | ☐ Receding jaw | ☐ Prominent jaw |
| ☐ Gummy smile | ☐ Spacing | ☐ Gum disease/recession | ☐ Missing teeth | ☐ Jaw dysfunction | ☐ Mouth too small |
| ☐ Clicking in jaw | ☐ Headaches | ☐ Irregular shaped teeth | ☐ Facial pain | ☐ Neck pain | ☐ Jaw pain |
| ☐ Crossbite | ☐ Underbite | ☐ Irregular facial proportions | ☐ Openbite | ☐ Impacted teeth | ☐ Finger/thumb sucking |

List other family members with same dental problems? _____

Does the patient have pain/clicking in the jaw joints? ☐ Yes ☐ No If yes, which side? ☐ Right ☐ Left ☐ Both

Does the patient grind/clench teeth? ☐ Yes ☐ No ☐ Unsure Does the patient have difficulty chewing? ☐ Yes ☐ No

Injury to face or teeth? ☐ Yes ☐ No If yes, please explain: _____

Has the patient been told they have a tongue thrust swallowing pattern? ☐ Yes ☐ No

Has the patient ever had orthodontic treatment? ☐ Yes ☐ No Explain: _____

How is the patient's general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has the patient reached puberty? ☐ Yes ☐ No If yes, approximate date: _____

Does the patient smoke? ☐ Yes ☐ No

Is there anything in the patient's medical history that we should be aware? ☐ Yes ☐ No

If yes, please explain: _____

Does the patient exhibit any developmental delays? ☐ Yes ☐ No If yes, please explain: _____

List all medications the patient is currently taking: _____

Have you ever taken intravenous bisphosphonates for serious cancers, such as Zometa or Aredia? ☐ Yes ☐ No

Have you ever taken oral or intravenous bisphosphonates for osteoporosis, osteopenia, or other uses such as:
Fosamax, Actonel, Boniva, Reclast, Skelid, Didronel, or Bonefos? ☐ No ☐ Currently taking ☐ Previously taken

Is the patient allergic to…?

Dental Anesthetics ☐ Yes ☐ No Nickel ☐ Yes ☐ No Latex ☐ Yes ☐ No

Other: _____

Has the patient ever had or been treated for:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart problems | ☐ Yes | ☐ No | Cancer | ☐ Yes | ☐ No | Epilepsy/Convulsions | ☐ Yes | ☐ No |
| Blood disorders | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No | Heart murmur | ☐ Yes | ☐ No |
| Kidney problems | ☐ Yes | ☐ No | Arthritis | ☐ Yes | ☐ No | HIV/AIDS | ☐ Yes | ☐ No |
| Sinus problems | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Breathing difficulty | ☐ Yes | ☐ No | Asthma | ☐ Yes | ☐ No | Fever blisters | ☐ Yes | ☐ No |
| Blood transfusion | ☐ Yes | ☐ No | Fainting | ☐ Yes | ☐ No | Rheumatic fever | ☐ Yes | ☐ No |
| Liver disease | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No | Severe headaches | ☐ Yes | ☐ No |
| Tonsillitis | ☐ Yes | ☐ No | Snoring | ☐ Yes | ☐ No | Tonsils Removed | ☐ Yes | ☐ No |
| High blood pressure | ☐ Yes | ☐ No | Low blood pressure | ☐ Yes | ☐ No | Autoimmune disorder | ☐ Yes | ☐ No |
| Adenoids removed | ☐ Yes | ☐ No | Blood disease | ☐ Yes | ☐ No | Sleep disturbance | ☐ Yes | ☐ No |
| Eating disorder | ☐ Yes | ☐ No | Mouth-breathing | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No |

Other medical problems: _____

Parent/Guardian name: _____ Date: _____

Signature: _____ Relationship to patient: _____

***It is extremely important to inform our office of any changes in medical history.***

LIBERTY HILL
ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

**Please Note: It is your right to refuse to sign this Acknowledgement.**

*Dental Office Use Only*

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date