THE SMILE STUDIO
ORTHODONTICS

NEW PATIENT INTAKE PAPERWORK

Patient Demographics:

Patient First Name: _____ Patient Last Name: _____

Patient Nickname (If Preferred): _____ Patient Date of Birth: _____

Patient Gender (Circle One): **MALE** **FEMALE**

Cell Phone Number: _____ Email: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

General Dentist Name: _____ **OR** Circle If Applicable **N/A**

Whom May We Thank for Referring You to Our Office?: _____

Primary Reason for Your Visit with Us: _____

_____

Motivating Factor for Receiving Orthodontic Treatment (Circle any That Apply): **AESTHETIC CARE** **FUNCTIONAL CARE**

OTHER, _____

Please Write a Few Hobbies or Interests You Currently Have: _____

_____

Favorite Movie(s) or TV Show(s): _____

Favorite Snack(s): _____

Favorite Color(s): _____

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Patient Health History:

Please Mark X in Each Applicable Answer Field Below:

Question:	YES	NO
Currently Sucks Thumb(s) or Finger(s):		
Pain or Clicking in Jaw Joint Area Upon Closing Mouth:		
Experiencing Noticeable Difference in Chewing or Swallowing:		
Been Informed of Any Missing or Extra Teeth:		

Please Circle Each Applicable Answer Below:

Main Breathing Method: **NOSE BREATHING** **MOUTH BREATHING** **BOTH**

Clench or Grind Teeth: **CLENCH DURING DAY** **CLENCH AT NIGHT** **GRIND DURING DAY** **GRIND AT NIGHT**

Preferred Treatment Method: **METAL BRACES** **CLEAR ALIGNERS** **DOCTOR'S SUGGESTION**

Preference on Additional Modalities: **NO RUBBER BANDS PLEASE** **NO HEADGEAR PLEASE** **FINE WITH EITHER!**

How Soon Would You Like Treatment: **ASAP, I'M EXCITED!!** **WITHIN 1-2 MONTHS**

STRONGLY CONSIDERING/ NO SET TIMEFRAME **JUST CURIOUS/ NOT SERIOUS**

Has Patient Ever Had Severe Head or Face Injuries? If yes, please explain: _____

_____

Have Any Teeth Been Injured or Chipped Due to Accidents? If yes, please explain: _____

_____

Have Any Teeth (Baby or Permanent) Been Removed by Extraction? If yes, please explain: _____

_____

Has Any Member of the Patient's Family Received Orthodontic Care? If yes, who? _____

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Patient Medical History:

Any Known Allergies? If yes, please Include Medications, Latex, etc.: _____

_____

Any Major Surgeries? If yes, please explain what and when: _____

_____

Currently Under Physician's Care? If yes, please explain: _____

_____

Taking Any Pills, Medications, or Drugs? If yes, please explain: _____

_____

Chronic Problems with Any of the Following (Circle ALL that Apply):

KIDNEY **LIVER** **HEART** **LUNG** **NONE** **OTHER,** _____

_____

Been Diagnosed or Treated for Any of the Following (Circle ALL that Apply):

DIABETES **ARTHRITIS** **BONE RECESSION** **OSTEOPOROSIS** **EPILEPSY** **ANEMIA**

ENDOCRINE DISEASE **ASTHMA** **FAINTING** **CEREBRAL PALSY** **PROLONGED BLEEDING**

HEART TROUBLE **RHEUMATIC FEVER** **TONSILS REMOVED** **ADENOIDS REMOVED**

_____

Substance Use (Circle Applicable):

Alcoholic Beverages: **NEVER** **RARELY** **SOMETIMES** **FREQUENTLY** **DAILY**

Smoking (Nicotine, Tobacco, or Other): **NEVER** **RARELY** **SOMETIMES** **FREQUENTLY** **DAILY**

Nicotine Pouches or Gum: **NEVER** **RARELY** **SOMETIMES** **FREQUENTLY** **DAILY**

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Patient Dental History:

ALL ANSWERS WILL BE KEPT CONFIDENTIAL AND ARE ONLY USED TO ASSESS THE SAFEST AND MOST EFFECTIVE FORM OF TREATMENT THAT WILL BE RECOMMENDED.

Does the Patient Want Their Teeth Straightened? (Circle One): **YES** **NO**

When Was the Patient's Most Recent Dental Check Up?: _____

Is There Any Pending Dental Work That Needs to be Completed by Your Dentist?: **YES** **NO**

Has the Patient Had Any Previous Consultation or Treatment?: **PREVIOUS CONSULTATION** **PREVIOUS TREATMENT** **N/A**

Has the Patient Ever Been Teased for the Appearance of Their Teeth? **YES** **NO**

Billing Party (Person Financially Responsible for Treatment Costs) Information:

Responsible Party (Circle One): **SAME AS ABOVE** **DIFFERENT PARTY**

Billing Party Employer: _____

Billing Party Marital Status: (Circle One): **SINGLE** **MARRIED** **PARTNERSHIP** **DIVORCED** **SEPARATED** **WIDOWED**

Billing Party Spouse Name (If Applicable): _____

If Billing Party is DIFFERENT than Patient, Please Fill Out Below:

Billing Party First Name: _____ Billing Party Last Name: _____

Billing Party Date of Birth: _____ Billing Party Gender: (Circle One): **MALE** **FEMALE**

Billing Party Cell Number: _____ Billing Party Email: _____

Billing Party Address: _____

Billing Party City: _____ Second Billing Party State: _____

Billing Party Zip: _____ Billing Party Relationship to Patient: _____

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Secondary Billing Party (If Splitting, Secondary Person Financially Responsible for Treatment Costs):

Second Billing Party First Name: _____ Second Billing Party Last Name: _____

Second Billing Party Date of Birth: _____ Second Billing Party Gender: (Circle One): **MALE** **FEMALE**

Second Billing Party Cell Number: _____ Second Billing Party Email: _____

Second Billing Party Address: _____

Second Billing Party City: _____ Second Billing Party State: _____

Second Billing Party Zip: _____ Billing Party Relationship to Patient: _____

Second Billing Party Employer: _____

Second Billing Party Marital Status: (Circle One): **SINGLE** **MARRIED** **PARTNERSHIP** **DIVORCED** **SEPARATED** **WIDOWED**

Second Billing Party Spouse Name (If Applicable): _____

_____

Dental Insurance Information:

Does the Patient Have Dental Insurance? (Circle One): **YES** **NO**

If You Circled YES on the Previous Question, Please Continue Answering Questions Below:

Policy Holder Full Name: _____

Policy Holder Date of Birth: _____ Policy Holder Social Security: _____

Policy Holder Full Address (Address, City, State, Zip): _____

_____

_____

Insurance Company Name: _____ Phone Number: _____

Member ID #: _____ Group #: _____

Employer that Insurance is Provided By: _____

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Secondary Dental Insurance Information (If Applicable):

Second Policy Holder Full Name: _____

Second Policy Holder Date of Birth: _____ Second Policy Holder Social Security: _____

Second Policy Holder Full Address (Address, City, State, Zip): _____

_____

_____

Secondary Insurance Company Name: _____

Secondary Member ID #: _____ Secondary Group #: _____

Secondary Insurance Phone Number: _____

Employer that Secondary Insurance is Provided By: _____

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Patient Informed Consent:

_____ 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:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
2. Obtaining payment from third party payers (i.e my insurance company)
3. Day- to- day healthcare operations of the practice

_____ I have been informed of and given the rights 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 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 these restrictions.

_____ I understand that as a courtesy to our patients that the practice provides an appointment reminder system that emails and text messages all patients and reminds them about their appointment date and time without specifically stating what type of appointment. I understand that I have the right to choose whether I want to be reminded of my appointment date and time by selecting the appropriate answer below.

_____ Yes, please use the automated system to remind me of appointment dates/ times.

_____ No, please do not use the automated system to remind me of appointment dates/ times.

_____ 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.

Patient Name (Printed): _____

Consenting Party First and Last Name (If different than patient): _____

Consenting Party Signature: _____ Date: _____

Witness Signature: _____ Date: _____