VINCENT & BULLWINKEL

ORTHODONTICS

Today's Date: _____

Patient's Date of Birth: _____

Patient's Name: _____ Age: _____ Sex: M ☐ F ☐

Patient's Preferred Name: _____ Primary Phone Number: _____

Home Address: _____ Zip Code: _____

School: _____ Grade: _____ Date of Last Dental Visit: _____

Patient's Hobbies or Interests: _____

Primary Dentist: _____ Primary Physician: _____

Whom may we thank for referring you? _____

Father's Name: _____ Occupation: _____

Employer: _____ Business Phone: _____

Business Address: _____ Soc Sec No: _____

Mother's Name: _____ Occupation: _____

Employer: _____ Business Phone: _____

Business Address: _____ Soc Sec No: _____

Who will be responsible for the account? _____ Relation to Patient: _____

Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐

Is the patient under care of a physician for a specific problem at the present time? Yes ☐ No ☐

Illness:_____

List any medications your child is currently taking: _____

List any drug sensitivities: _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ High Blood Pressure	☐ Allergies or Asthma	☐ Speech Problems
☐ Glaucoma	☐ Head or Facial Injury	☐ Rheumatic Fever	☐ Emotional Problems
☐ Heart Trouble	☐ Tonsillitis	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Hearing Disorder	☐ Bleeding Problems	☐ Nervous Disorders
☐Hepatitis/Liver Disease	☐ Chronic Ear Infections	☐ Epilepsy	☐ Adopted

Has the patient reached puberty? Yes ☐ No ☐ If yes, when (month/year)? _____

Is there a history of serious illness, accident, or operation? Yes ☐ No ☐

Please List: _____

Have there been any injuries to the face/mouth/teeth? _____

Has the patient every sucked their thumb or fingers? _____

Until what age? _____

Has an orthodontist been consulted previously? _____

Has the patient has previous orthodontic treatment? _____

Where? _____

Have you been informed of any mission or extra permanent teeth? _____

Has either parent ever had orthodontic treatment? _____

At what age? _____

Please list any family member previously treated by our practice: _____

Names and ages of other children in the family: _____

Please complete the following information to help us evaluate for family growth patterns:

Father's Height: _____ Mother's Height: _____ Patient's Height: _____ Weight: _____

What part of your child's orthodontic problem concerns you the most? _____

_____

Please list additional information which you feel would help make your child's association with us more enjoyable: _____

_____

_____

Signature of Parent/Guardian

PEDIATRIC SLEEP QUESTIONNAIRE

	Yes	No	Don't Know
While sleeping does your child...			
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have "heavy" or loud breathing?			
Have trouble breathing or struggle to breathe?			
Have you ever...			
Seen your child stop breathing during the night?			
Does your child....			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Wake up feeling un-refreshed in the morning?			
Have a problem with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
This child often...			
Does not seem to listen when spoken to directly			
Has difficulty organizing g tasks			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Is "on the go" or often acts as if "driven by a mot or"			
Interrupts or intrudes on others (e.g. butts into conversations or games)			

Total Number of "Yes" Responses _____

If eight or more statements are answered "yes", consider referring for sleep evaluation.

Do you have dental insurance that covers orthodontic treatment? Yes ☐ No ☐

If yes, please complete next page

DENTAL/ORTHODONTIC INSURANCE INFORMATION

To best assist your family in determining orthodontic benefits, the following information is necessary.

Name of Patient: _____ Date of Birth: _____

Name of Insured: _____ Date of Birth: _____

Relationship to patient: _____

Address: _____

Social Security #: _____ Telephone: _____

Employer: _____ Telephone: _____

Employer's Address: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

IF THE PATIENT HAS ADDITIONAL COVERAGE, PLEASE PROVIDE THAT INFORMATION BELOW

Name of Insured: _____ Date of Birth: _____

Relationship to patient: _____

Address: _____

Social Security #: _____ Telephone: _____

Employer: _____ Telephone: _____

Employer's Address: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

I hereby authorize the release of any information relating to this claim.

_____ _____

Signature Date

I hereby authorize the payment of insurance benefits directly to the named orthodontist.

_____ _____

Signature Date

ACKNOLWEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Patient's Name: _____

I, _____ have received a copy of this office's notice of privacy practices.

Name (Please print): _____

Signature: _____

Date: _____

Email Address: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other: _____

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