NEWTOWN ORTHODONTICS

Dr. Randolph E. Schader

PATIENT INFORMATION - MINOR

Patient's Name: _____ DOB: _____Male/Female
Hobbies/Interests: _____
Attends school at: _____

Number of siblings: _____
Sibling's Name: _____ DOB: _____ Male/Female
Sibling's Name: _____ DOB: _____ Male/Female
Sibling's Name: _____ DOB: _____ Male/Female
Sibling's Name: _____ DOB: _____ Male/Female

PARENT INFORMATION

Mother's Name: _____ __Married __Divorced __Single__Widowed
Address: _____City:_____State:____Zip:_____
Home #: _____Cell #: _____Email address: _____
Mother's Employer: _____ Work #: _____

Father's Name: _____ __Married __Divorced __Single__Widowed
Address(if different):_____City:_____State:____Zip:____
Home #: _____Cell #: _____Email address:_____
Father's Employer: _____ Work #: _____

General Dentist:_____ Date last seen:_____

PRIMARY DENTAL INSURANCE

Policy Holder's Name: _____DOB: _____
ID #/Social Security #: _____Group #: _____
Employer: _____
Dental Insurance Plan Name & Address: _____
_____
_____

REFERRAL INFORMATION

Name of person/office referring you to our practice:_____
Emergency contact (not living with you) :_____
Address:_____Phone #:_____

Signature:_____Date:_____Relationship to child:_____

NEWTOWN ORTHODONTICS

Dental and Health History

Name_____ D.O.B. _____ Gender M F

First Middle Last

Dental Orthodontic History	Yes	No	Additional Information
Thumb/Finger sucking			
Tongue thrust			
Clenching/Grinding teeth			
Mouth breathing habit, snoring or difficulty in breathing			
Chipped or otherwise injured primary (baby) or permanent teeth			
Difficulty in chewing or jaw opening			
Had periodontal (gum) treatment			
Teeth sensitive to hot or cold			
Speech problems			
Supernumerary (extra) or congenitally missing teeth			
Had prior orthodontic examination or treatment			
Bleeding gums, bad taste or mouth odor			
Periodontal "gum" problems			
Any pain or soreness in the muscles of the face or around the ears			
Aware of any loose, broken or missing restorations (fillings)			
Using any forms of fluoride			
Suffered injuries to your face, mouth, teeth or chin			

Medical History	Yes	No
Abnormal Bleeding		
Hypertension		
ADD		
ADHD		
AIDS/HIV		
Any operation		
Artificial Joints/Valves		
Asthma		
Cancer		
Congenital Heart Disorder		
Convulsions		
Diabetes		
Epilepsy		
Handicaps/Disabilities		
Heart Murmur		
Hemophilia		
Hepatitis		
Kidney Problems		
Liver Problems		
Mitral Valve Prolapse		
Prosthetics		
Rheumatic Fever		
Scarlet Fever		
Sickle Cell Disease		
Tuberculosis (TB)		

Medical History

Primary Physician_____

Phone Number_____

Last Visit_____

Current Physical Health is: Good____ Fair____

Poor____Explain_____

List medications currently taking

_____

Is pre-med required for dental visits (please circle) No Yes

Explain_____

Allergies to medications: No _____ Yes ____ Explain_____

Other allergies No_____ Yes____

Latex____Metals____Nickel____Plastic____other_____

Authorization

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is my responsibility to inform Newtown Orthodontics of changes in my child's or my own medical status. I authorize the orthodontic staff to perform the necessary dental and/or orthodontic services on my child (if applicable) or myself as needed.

_____ _____

Patient signature (legal guardian if minor) Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

Randolph Schader, DDS, MS
Newtown Orthodontics LLC
46 Blacksmith Rd, "Suite Tooth"
Newtown, PA 18940

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** patient name Parent/Guardian Please ***sign***

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message ☐ **Any of the Above**
□ Text Message ☐ **None of the above** (opt out)
□ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___ _____
Signature of Privacy Officer