Child Patient Information

Patient's name_____
Last First Middle

Address _____
Street City Zip

Home Phone_____Cell Phone_____ Birthdate _____

Who is Custodial Parent? _____

Whom do you authorize to discuss your child's treatment? _____

Whom do you authorize to discuss financial information? _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Father/ (circle one)

Stepfather _____ E-Mail _____
Last First Middle

Home Phone_____Work Phone_____Cell Phone_____

Address _____
Street City Zip

Years at above address?_____ SS#_____-_____-_____ Birthdate _____

Employer_____ Occupation_____ No. years employed _____

Dental Ins. Co. _____Phone_____ID# _____

Mother/ (circle one)

Stepmother _____ E-Mail _____
Last First Middle

Home Phone_____Work Phone_____Cell Phone_____

Address _____
Street City Zip

Years at above address?_____ SS#_____-_____-_____ Birthdate _____

Employer_____ Occupation_____ No. years employed _____

Dental Ins. Co. _____Phone_____ID# _____

Additional

Insured _____ Birthdate _____
Last First Middle

Employer_____ Occupation_____ No. years employed _____

Dental Ins. Co. _____Phone_____ID# _____

Emergency Information

Name of nearest relative not living with you _____

Complete address_____
Street City Zip

Phone _____

Signature (Parent's signature if minor) _____

MEDICAL HISTORY

Patient Name _____
Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

Yes No Are you allergic to latex?

DENTAL HISTORY

Dentist_____ Date of Last Dental Cleaning and Checkup _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment?
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____
Female Patients only:
Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Housley and/or Dr. Dobson to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

JEFFREY A. HOUSLEY, DDS, MS BRENT S. DOBSON, DDS, MS

YOUR SMILE IS OUR SPECIALTY
BOARD CERTIFIED ORTHODONTISTS

PATIENT REQUEST FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION & CONSENT FOR CELL PHONE CONTACT

I, the undersigned, hereby request that Owasso Orthodontics communicate about all Protected Health Information (PHI) by conventional, unencrypted email. This PHI includes, but is not limited to: potential treatment plans, fees associated with treatment, insurance information, birthday well wishes, appointment dates/times and treatment progress.

I understand that this increases the risk that the PHI could be read or accessed by a third party while in transit. If my PHI is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this request at any time by delivering a revocation in writing to Owasso Orthodontics. After that point, email communication with me about all PHI will be protected by password encryption. If I revoke this request, it will have no effect on actions already taken by Owasso Orthodontics in reliance on this request.

I authorize the request described herein. I have read and understand this request. I am the patient listed on this request or am authorized to act on behalf of the patient as the patient's personal representative.

☐ I consent to Owasso Orthodontics using my cell phone number to call and/ or text regarding appointments, insurance, and my account. I understand that I can withdrawal my consent at any time.

My cell phone number is: _____

Printed Name of Patient: _____

Printed Name of Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

Date: _____

Witness:_____

E-mail:_____

12813 East 101st Place North Owasso, OK 74055 (918) 272-4242 (918) 272-5753 Fax
www.OwassoOrthodontics.com

JEFFREY A. HOUSLEY, DDS, MS BRENT S. DOBSON, DDS, MS

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BOARD CERTIFIED ORTHODONTISTS

Assignment of Benefits and Authorization Release

I hereby authorize and request my insurance company to assign benefits directly to my orthodontist. If my current policy prohibits direct payment to my orthodontist, I hereby agree to pay the orthodontist the sum equal to the insurance payment received by me. I shall mail the check as follows:

Payable to: Owasso Orthodontics
Mail to: Owasso Orthodontics
12813 E. 101st Place North
Owasso, OK 74055

I authorize the treatment provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, and for any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Signature of Subscriber Date

Subscriber Name: _____

Patient Name: _____

Subscriber D.O.B.: _____

Subscriber SSN or Member ID: _____

Employer: _____

Insurance Company: _____

Insurance Phone: _____

Email to: info@owassoorthodontics.com
Fax to: 918-272-5753