PATIENT INFORMATION FOR MINORS (below age 18)
(INFORMACION DEL PACIENTE PARA MENORES (menores de 18 años))

Date (Fecha): ____________________

Patient's name (Nombre del paciente): ____

Nickname (Apodo): _______________________

Gender (Sexo): _____ Male _____ Female Birthdate (Fecha de Nacimiento): ____________________________

School (Escuela): _____________________________________

Sports/Hobbies (Deporte/Pasatiempos): ____

PARENT INFORMATION (Informacion del responsable) Please give primary on insurance if applicable.

Name (Nombre): ____

Relationship to Patient (Relación al paciente): ____ (Mom)(Madre) ____ (Dad)(Padre) ____ (Guardian/Other)(otro): ______________

Street Address (Dirección): ____

City/County (Ciudad/País): _______________________ State (Estado): _______ Zip(Código postal): _______________________

Phone (Teléfono): ____________________________________ Phone type (Type de teléfono): ______________________________

Other phone (Otro teléfono): ____________________________ Phone type (Type de teléfono): ______________________________

Email: ____ Social Security # (No. de Seguro Social): ____________________________

Birthdate (Fecha de Nacimiento): __________________________ Occupation (Ocupación):____________________________

Name of other parent/guardian (Nombre de otro pariente/guardián)): ____

Name of person to contact in case of an emergency (En caso de emergencia, ¿a quién se deberá notificar?) :
____

Phone (Telefono): ____

DENTAL INSURANCE INFORMATION (INFORMACION DEL SEGURO DENTAL)

Primary Insured's Name (Nombre del asegurado): ____

Insured's Social Security # (No. de Seguro Social): ___________________________

Insured's birthday (Nacimiento del asegurado): _______________________________

Insurance Company (Nombre de la compañía del Seguro Dental):____

Group No. (Número del grupo):_____________________________ Member ID No. (No. De Poliza): ___________________________

Insurance phone number (Teléfono del Seguro) ___________________________________

DENTAL HISTORY (Historia Dental)

Name of your dentist (Nombre de su dentista):____

Phone # (Teléfono):____

Approximately how long ago was the patient's last visit to the dentist? (Fecha de la última visita al dentista?)

____

What is the reason for seeking a consultation from an orthodontist? (¿Cuál es la razón para buscar una consulta con un ortodoncista?)

____

How did you hear about our office? (¿Cómo se enteró de nuestra oficina?)

____

YES NO

____ ____ Is the patient presently in any dental pain? If so, where: ____
(¿Está el paciente actualmente en dolor dental? Si la respuesta es afirmativa, ¿dónde?)

____ ____ Has the patient ever had braces, expanders, retainers, or Invisalign before?
(¿El paciente ha tenido frenos, expansores, retenedores o Invisalign antes?)

____ ____ Has the patient ever had an orthodontic consultation before?
(¿El paciente alguna vez ha tenido una consulta de ortodoncia?)

____ ____ Have there been any injuries to face, mouth, or teeth?
(¿Ha habido alguna lesión a la cara, la boca o los dientes?)

____ ____ Has the patient ever been diagnosed with gum disease?
(¿El paciente ha sido diagnosticado con la enfermedad de las encías?)

____ ____ Has the patient ever had history of jaws locking up, jaw pain, or limited jaw movements?
(¿Alguna vez ha tenido el paciente dolor en la mandíbula o movimientos mandibulares limitados?)

____ ____ Has the patient ever had a history of sleep apnea?
(¿Ha teniedo el paciente apenea del sueño?)

MEDICAL HISTORY (Historia Medico)

YES NO

____ ____ Is the patient taking any medication? ____
(¿Está tomando Ud. actualmente algún medicamento)

____ ____ Is the patient allergic to metal, latex, or any medication?
(¿Tiene Ud. alguna alergia a metal, látex, o algún medicamento?)

If so please list (¿Cuáles?): ____

____ ____ Any medical conditions? ____
(¿Alguna condición médica?)

____ ____ Has the patient had any operations? ____
(¿Ha tenido alguna cirugía?)

____ ____ Ever been involved in a serious accident? ____
(¿Alguna vez ha sido involucrado en un accidente grave?)

Circle any of the medical conditions below that the patient has had or currently has.
(Por favor marque Sí o No)

YES	NO		YES	NO	
____	____	Heart Problems (Problemas del Corazón)	____	____	ADHD (TDAH/trastornos sensoriales)
____	____	Diabetes	____	____	Epilepsy (Epilepsia)
____	____	Asthma or Hay fever (Enfermedades Respiratorias)	____	____	Abnormal bleeding /Hemophilia (Enfermedad de la Sangre/Hemofilia)
____	____	HIV / Aids (VIH/SIDA u Otros Trastornos Inmunosupresores)	____	____	Bone Disorders

Are there any medical conditions we have not discussed that you feel we should be aware of?
(¿Hay alguna otra cosa que nosotros debiéramos saber sobre su historia clínica?)

____

Female Patients only: (Para pacientes femeninas)
Has menstruation started? (Empezo la menstruación): _____ (Yes/ Sí) _____ (No)
Is the patient pregnant? (¿Sospecha Ud. que está embarazada?): _____ (Yes/ Sí) _____ (No)

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. Jones to perform a complete orthodontic evaluation.
(He contestado sinceramente a todas las preguntas y estoy de acuerdo de informar a esta oficina de cualquier cambio en mi historial médico o dental. Asimiso, autorizo a la Dra. Jones para realizar una evaluación de ortodoncia completa.)

Signature (Firma):____Date (Fecha):___________________

PATIENT RECORD OF DISCLOSURES (REGISTRO DE DIVULGACION DEL PACIENTE)

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (Deseo que me contacten de la siguiente manera)

- Home Telephone:_________________________
- Work Telephone:__________________________
- Cell Number: _____________________________
- Written Communication (Email or Post Mail):____

PLEASE LIST ANY PERSON(S) WHOM YOU ARE AUTHORIZING US TO DISCLOSE INFORMATION REGARDING YOUR ORTHODONTIC TREAMTENT: (POR FAVOR MENCIONE CUALQUIER PERSONA A LA QUE USTED NOS AUTORIZA A DIVULGAR INFORMACION SOBRE SU TRATAMIENTO DE ORTODONCIA)

NAME:____ PHONE:________________________RELATIONSHIP:__________

NAME:____ PHONE:________________________RELATIONSHIP:__________

NAME:____ PHONE:________________________RELATIONSHIP:__________

PLEASE LIST ANY PERSON(S) WHOM YOU ARE <u>NOT</u> AUTHORIZING US TO DISCLOSE INFORMATION REGARDING YOUR ORTHODONTIC TREATMENT: (POR FAVOR MENCIONE CUALQUIER PERSONA A LA QUE <u>NO</u> NOS AUTORIZA A DIVULGAR INFORMACION SOBRE SU TRATAMIENTO DE ORTODONCIA)

NAME:____ PHONE:________________________RELATIONSHIP:__________

NAME:____ PHONE:________________________RELATIONSHIP:__________

NAME:____ PHONE:________________________RELATIONSHIP:__________

Appointment Policy for **NEW PATIENT**

Thank you for choosing our office for your orthodontic care. We value the time you invest for your appointments. As you may be aware, orthodontic treatments can take several months to years to complete. In order to ensure that you are seen in a timely manner and that your treatment progresses accordingly, we ask all of our patients to honor our appointment policy. We appreciate your compliance and we look forward to serving your orthodontic needs.

- **Patients who arrive late may not be seen and will result in a no-show.**
- Please allow at least **ONE BUSINESS DAY** prior notice to reschedule or cancel the appointment(s) in order to avoid a $50 no-show fee.
- A no-show is defined as:
    - Complete no-show on the day of the appointment
    - Cancelation on the day of the appointment
    - Rescheduling on the day of the appointment
    - Arriving late which will result in rescheduling appointment for another day

After-School Appointments

We strive to accommodate children in school with afternoon appointments. However, certain procedures will need to be scheduled in the morning. Please expect some missed days of school throughout the course of treatment.

Many of our patients are children who are currently attending school. According to the American Association of Orthodontics (AAO), children undergoing orthodontic treatment may miss 3 to 4 school days per year. AAO research has demonstrated that children who miss school due to orthodontic treatment do NOT suffer academically. Instead, the research indicates that children who receive orthodontic care often do better in school compared to their peers.

Signature: ___________________________________ Date: ________________________________