

DENTAL INSURANCE INFORMATION

This information is a confidential part of our patient records. Thank you.

Patient's Name: _____

Full-time student Yes No School/City: _____

Date of birth: _____ Age: _____ Male Female

PRIMARY DENTAL INSURANCE COMPANY INFORMATION

Group No: _____

Ins. Company Name: _____

City: _____ State: _____ Zip: _____

Phone No: area code: () _____

Insured's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Employer: _____

SECONDARY DENTAL INSURANCE COMPANY

Group No: _____

Ins. Co. Name: _____

City: _____ State: _____ Zip: _____

Phone No: area code: () _____

Insured's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Employer: _____

Please call our office if you require assistance in filling out this form. We would be happy to assist you. (650) 994 -1818 ... or 994-1212

For Office use only PRIMARY Lifetime Max: _____ % _____ Ded. Met: Yes No Amount Used: _____ Remaining: _____

For Office use only SECONDARY Lifetime Max: _____ % _____ Ded. Met: Yes No Amount Used: _____ Remaining: _____

For Office use only TRANSFER PATIENT Lifetime Max: _____ % _____ Ded. Met: Yes No Amount Used: _____ Remaining: _____ Pt.: prior paid: _____
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DENTAL HISTORY

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Patient's name _____ Birth date _____
Last First Middle

Please answer all questions checking either YES or NO

- Does the patient presently suck his/her thumb or fingers?..... Yes No
 - Does the patient breathe mostly thorough his/her mouth?..... Yes No
 - Has the patient ever received a severe blow resulting in injury..... Yes No
to the teeth or jaws?
 - Does the patient grind (brux) his/her teeth at night?..... Yes No
 - In the past, has the patient ever complained of:
 - Clicking or popping noise of the jaw joints?..... Yes No
 - Stiffness or soreness of the jaws and jaw muscles?..... Yes No
 - Episodes when the jaws would not open or close normally?..... Yes No
 - Pain or discomfort in the area in front of the ear?..... Yes No
- If yes, please write dates and details on the reverse side.

GROWTH INFORMATION

Patient's Height____Weight____Estimated growth rate: Fast Slow Average Completed

Approximately how tall do you expect the patient to be at maturity? _____

How much did the patient grow in the last year?_____

Father's height_____Mother's height_____

Female patients only: Has the patient started her monthly periods?..... Yes No

Male patients only: Has the patient's voice changed noticeably?..... Yes No

MEDICAL HISTORY Patient's Physician Dr. _____

Address _____

Has patient had his/her tonsils or adenoids removed?..... Yes No

Has patient ever had an unusual reaction to any drug such as penicillin?

other antibiotics, aspirin or local anesthetic?..... Yes No

If yes, please describe _____

Has patient ever had any surgery of the mouth area?..... Yes No

If yes, please describe _____

Has patient had any of the following: Please circle

- | | |
|------------------------|---------------------------------------|
| (1) Arthritis | (11) Allergies |
| (2) Anemia | (12) Asthma |
| (4) Epilepsy | (14) Major surgery |
| (5) Nervous disorder | (15) Tuberculosis |
| (6) Hyperactivity | (16) Heart disorders |
| (7) Mental retardation | (17) Previous orthodontics |
| (8) Emotional problems | (18) Thyroid or hormonal imbalance |
| (9) Diabetes | (19) Communicable diseases (venereal) |
| (10) Frequent colds | (20) Blood disorders |

Does the patient have a speech problem..... Yes No

Does the patient exhibit a tongue thrusting, or reverse swallowing problem?.... Yes No

Is patient receiving speech therapy?..... Yes No

Is patient presently under the care of a physician or receiving any medication? Yes No

If so, please explain _____

Parent or guardian's signature _____ **Date** _____

Please provide comments you feel may be helpful or pertinent to the medical, dental or growth history of this patient. Do you feel the patient is sufficiently mature to assume the responsibilities of orthodontic treatment? _____

PATIENT CONSENT FORM

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 your office to use and disclose my protected health information to carry out the following:

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

I have also been informed of, and given the right 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 that 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 this restriction.

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.

Signed this _____ day of _____, 20_____.

Please print Patient's Name: _____

Relationship to Patient: _____

Signature: _____

Ernest A. Maggioncalda, D.D.S., Inc.
4943 Junipero Serra Blvd.
Colma, CA. 94014 (650) 994-1818

PERSONAL INFORMATION

Date _____

This information is a confidential part of our patient records

Patient's name _____ Date of Birth _____

Address _____ Phone # () _____

City _____ State _____ Zip _____

School _____ Age _____ months _____

Dentist Name _____ Phone # _____

Address/City/Zip _____

Father/Guardian _____ Occupation _____

Employer _____ How long _____

Business address _____ Business phone () _____

Soc. Security # _____ Cell phone # _____

Date of Birth _____

Mother/Guardian _____ Occupation _____

Employer _____ How long _____

Business address _____ Business phone () _____

Social Security # _____ Cell phone # _____

Date of Birth _____

Married _ Separated _ Divorced _ Widowed _ Partners ε

Patient lives with φ parents φ mother φ father φ step-parent φ grandparent φ other

Person responsible for account _____ Phone# () _____

Address _____

If transfer patient from another office, please provide previous orthodontist contact information:

Dr. _____ Address: _____

Phone #() _____ No. of years/mos. in treatment _____

You were referred to our office by _____

Other family members former or present patients at our office? _____

Is patient your natural child? Yes _ No _ Adopted _ Grandchild _ Foster _

Previous marriage _ relative ε Other ε _____