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: _________

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

(2) Anemia

(4) Epilepsy

(5) Nervous disorder

(6) Hyperactivity

(7) Mental retardation

(8) Emotional problems

(9) Diabetes

(10) Frequent colds

(11) Allergies

(12) Asthma

(14) Major surgery

(15) Tuberculosis

(16) Heart disorders

(17) Previous orthodontics

(18) Thyroid or hormonal imbalance

(19) Communicable diseases (venereal)

(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:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Other payment from third party payers (i.e. my insurance company)
- 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 Practice*s, 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 _______________________________

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