dr. stuart frost

A Future Full of Smiles, Let It Begin With Us

## PATIENT INFORMATION

Patient's name______________________________________________Age________ Sex: F ( ) M ( )
Birthdate____/____/____ Social Security #_________________ E-Mail ________________________
May we add you as a friend on our Frost Orthodontics Facebook Page? YES______ NO______
Home Address _______________________________________________________________
City, State _____________________________ Zip ________ How long at this address?___________
Home Phone _______________________ School ____________________ Grade ___________
If patient is a minor, give custodial parent's name or guardian's name ______________________________
Patient's hobbies ____________________________________________________________
Siblings Names and Ages:_______________________________________________________
General Dentist _________________________ Dentist Phone _____________________________
Who may we thank for referring you to our office? _________________________________________

## RESPONSIBLE PARTY INFORMATION

Primary____________________________________ Marital Status _____ E-Mail_________________
Home Address__________________________________________________ Own ( ) Rent ( )
City, State __________________________________ Zip _______ How long at this address: _______
Home Phone __________________ Work Phone __________________ Cell Phone ____________
Social Security # _________________ Birthdate ____/____/____ Relationship to patient ____________
Employer _______________________ Occupation _______________ # years employed___________
Secondary__________________________________ Marital Status _____ E-Mail_________________
Home Address__________________________________________________ Own ( ) Rent ( )
City, State __________________________________ Zip _______ How long at this address: _______
Home Phone __________________ Work Phone __________________ Cell Phone ____________
Social Security # _________________ Birthdate ____/____/____ Relationship to patient ____________
Employer _______________________ Occupation _______________ # years employed___________

## DENTAL INSURANCE INFORMATION

Insured's Name _____________________________ Insurance ID # _______________________
Insured's Birthdate ____/____/____ Relationship to patient ________________________
Insurance Company___________________________ Phone # ____________________________
Employer ________________________________________ Group # _________________________
Do you have dual coverage? YES NO If yes, please complete the following section:
Insured's Name _____________________________ Insurance ID # _______________________
Insured's Birthdate ____/____/____ Relationship to patient ________________________
Insurance Company___________________________ Phone # ____________________________
Employer ________________________________________ Group # _________________________

## EMERGENCY INFORMATION

Name of nearest relative not living with you_________________ relationship__________________
Address __________________________________________ Home phone ____________________
City, State ________________________ Zip _____________ Work phone ____________________

I understand that the information I have given is correct and I authorize the dental staff to perform the necessary dental services my child may need. I understand where appropriate, credit bureau reports may be obtained.

Signature(parent/guardian if minor) _____________________________________________________

Date ____________________

## MEDICAL INFORMATION

Please check box if patient currently has, or has a history of, any of the following:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Allergies | ☐ | Endocrine/Thyroid problem | ☐ | Latex allergy |
| ☐ | Anemia | ☐ | Fainting | ☐ | Liver/Kidney problem |
| ☐ | Artificial bones/joints/valves | ☐ | Fever blisters/Herpes | ☐ | Nervous/Hyperactive |
| ☐ | Asthma | ☐ | Frequent headaches | ☐ | Prolonged bleeding |
| ☐ | Blood transfusion | ☐ | Glaucoma | ☐ | Removal of tonsils/adenoids |
| ☐ | Bone disorder | ☐ | Handicaps/Disabilities | ☐ | Rheumatic fever |
| ☐ | Cancer | ☐ | Hearing problems | ☐ | Tobacco use |
| ☐ | Convulsions | ☐ | Heart problems | ☐ | Tuberculosis |
| ☐ | Emotional problems | ☐ | HIV (tested positive)/AIDS | ☐ | Venereal disease |

Is patient in good health? YES NO

Is patient under physician's care? YES NO

If so, for what reason____________________

Are there any other/ongoing medical conditions? YES NO

If so, describe____________________

Is patient taking prescription medications? YES NO

If so, list____________________

For children and adolescence only:

Has puberty been reached? (Start of menstruation or voice change) YES NO

If so has it been within the last two years? YES NO

## DENTAL HISTORY

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Any missing teeth? | | | Any extra teeth? | | |
| Any nighttime clenching or grinding? | | | Clicking or pain when opening jaws? | | |
| Any speech problems? | | | Surgery to repair cleft lip or palate? | | |
| Frequent mouth breathing? | | | Has patient ever seen an orthodontist? | | |
| Have parents had orthodontic treatment? | | | Has patient ever sucked thumb or finger? | | |
| Has patient had a recent dental check-up? | | | Date of last dental check-up: ____________________ | | |

| | YES | NO |
|---|---|---|
| Have any primary/permanent teeth been removed by extraction? | | |
| Has patient been ridiculed about the appearance of his/her teeth? | | |
| Would patient mind wearing braces? | | |
| Has a dentist ever placed a retainer or space maintainer? | | |
| Does anyone in the family have similar dental conditions as the patient? | | |
| Is patient adopted? | | |
| Does the patient resemble mother or father more? (Please circle one) | Mother | Father |

What are your main concerns that you would like Dr. Frost to address? ______________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Frost Orthodontics
Patient Privacy Consent

This form is Optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign, and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations. (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's private notice prior to signing this copy of which was given to you with this Consent.

You have to right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

____________________________________________
Patient's Signature/Parent or Guardian Signature

____________________________________________
Print Name

____________________________________________
Date