



306 U.S. Route 1  
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www.facebook.com/howardortho

## Child Registration Form

Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_

Does the patient have a nickname? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

**Whom should we thank for referring you to our office?** \_\_\_\_\_

Name of patient's general Dentist: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Has anyone in your family been treated in our office? \_\_\_\_\_

Sibling(s) & age(s): \_\_\_\_\_

### Parent/Guardian

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Mobile Carrier: \_\_\_\_\_

### Parent/Guardian

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Mobile Carrier: \_\_\_\_\_

Person responsible for the account: \_\_\_\_\_

Person responsible for making appointments: \_\_\_\_\_

Please circle how you would like to receive appointment reminders: Email   Text Message   Both

**Please help us to understand your child's dental condition and experiences by answering the following:**

**Has your child ever had:**

Y N Abscessed or extracted teeth?

Y N Injured or chipped teeth?

Y N Any severe head injuries?

Y N Sore or bleeding gums?

Y N Limited opening of jaw?

Y N Numbness or tingling of the face?

Y N Previous orthodontic treatment? \_\_\_\_\_

Y N Bleeding that was hard to stop?

Y N Been hospitalized? If so, for what? \_\_\_\_\_

Y N Is your child allergic to any drug or other substances? If so, what? \_\_\_\_\_

Please list all medications your child is currently taking: \_\_\_\_\_

Females: Has your child started menstruating? Yes No At what age? \_\_\_\_\_

Males: Has your child's voice changed? Yes No At what age? \_\_\_\_\_

Describe your child's current overall health: (circle one) Excellent Good Fair Poor

**Has/Does your child:**

Y N Suck fingers or thumb? Until what age: \_\_\_\_\_

Y N Breath predominately through their mouth?

Y N Clench or grind their teeth?

Y N Have missing permanent teeth?

Y N Have extra permanent teeth?

Y N Do any family members have a similar condition?

Y N Is your child **allergic** to Latex?

**Please Circle All Conditions That Apply**

Heart murmur

Heart surgery

Rheumatic/Scarlet fever

Heart pacemaker

Artificial heart valve

Artificial joints

High/Low blood pressure

Shortness of breath

Chest pains

Tactile defensive

Hives/Rash

ADD/ADHD

Frequent headaches

Depression

Thyroid disorder

Sinus trouble

Hepatitis

Asthma

Tuberculosis

Bronchitis

Hay fever/Allergies

Epilepsy

Fainting

Aids/HIV

Emotional problems/issues

Diabetes

Nervous/Anxious

Immune system disorders

STD

Autism

**Has your child:**

Expressed objections to wearing braces or headgear? Y N

Expressed anxiety about treatment? Y N

Been teased about the appearance of their teeth? Y N

Been interested in having their teeth straightened? Y N

Had an orthodontic evaluation before? Y N If yes, how long ago? \_\_\_\_\_ Was treatment recommended? Y N

Has any member of your family experienced orthodontic treatment? Y N If yes, who? \_\_\_\_\_

Are you aware that some of your child's orthodontic appointments will infringe on school time? Y N

Who first noticed the need for orthodontic treatment? \_\_\_\_\_

What is your main reason for seeking an orthodontic evaluation today? \_\_\_\_\_

Is there any condition or other information that you think would be helpful for us to know about before we meet your child?

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Today's Date

# Welcome Form

We would like to get to know you better.  
Please give us some information  
about yourself and the things that you like to do.

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Your Full Name: \_\_\_\_\_

Do you have a Nickname? \_\_\_\_\_

What kind of music do you like and who are your favorite performers or groups? \_\_\_\_\_

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What kind of books or movies do you like? \_\_\_\_\_

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Are you involved in sports, dance or other extracurricular activities? \_\_\_\_\_

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Do you have any hobbies? \_\_\_\_\_

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Do you play any musical instruments? \_\_\_\_\_

Is there a subject you like most in school? \_\_\_\_\_

What would you like to do when you finish school? \_\_\_\_\_

Do any of your friends come to our office? If so, who? \_\_\_\_\_

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Are you on facebook? Y N

Please join us @ [www.facebook.com/howardortho](http://www.facebook.com/howardortho)





## Orthodontic Benefits Form

Orthodontic "insurance" is different than regular dental coverage. Typically orthodontic benefits are a lifetime maximum amount as part of your dental insurance plan. We have prepared this form for you to easily verify your coverage.

Name of Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employee: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Employee date of birth: \_\_\_\_\_  
Employee SS# or ID#: \_\_\_\_\_ Payer ID# \_\_\_\_\_  
Group#: \_\_\_\_\_

**Please be sure to call your dental insurance company prior to your scheduled appointment and gather the following information.**

Do I have orthodontic coverage? YES NO  
If YES continue with the following questions:

Lifetime Maximum? \_\_\_\_\_  
Paid at what percentage? \_\_\_\_\_  
Is there a deductible? \_\_\_\_\_  
Is there a waiting period? \_\_\_\_\_  
Is there an age limit? \_\_\_\_\_  
Have I used any benefits? \_\_\_\_\_ How much? \_\_\_\_\_  
Effective date of policy? \_\_\_\_\_  
How are benefits paid? \_\_\_\_\_

Please record the name of the representative you speak with: \_\_\_\_\_  
Date of your call: \_\_\_\_\_

NOTE: If your policy is one that combines orthodontic and general dental benefits please make sure you request how much benefit is paid per calendar year and how much has been used to date.

## PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, Dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To others health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine results of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment;
- To your family and close friends involved with your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) of the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice sitting forth our legal duties and privacy practices with respect such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

#### PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

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Patient (guardian if under age 18)

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Date

#### 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, email 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 privacy notice prior to signing this Consent, a copy of which is attached.

You have the 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.

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Patient (guardian if under 18)

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Date