CHILD
PATIENT INFORMATION
& MEDICAL HISTORY

Great Smiles
ORTHODONTIC SPECIALISTS

BeGreatDental.com

Ryan J. Haldeman, DDS, MS, PA
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Patient Information

Date _____

Patient's Name _____ (First / Middle / Last) Preferred Name _____ Sex _____

Physical Address _____ Date of Birth _____ Age _____ Weight _____

Child lives with: ❑ Both parents ❑ Mother ❑ Father ❑ Other School Name _____

Patient's Physician or Pediatrician Name _____ Patient's Dentist _____

Whom may we thank for referring you? _____

Responsible Party Information

Name _____ (First / Middle / Last) Marital Status: ❑ Single ❑ Separated ❑ Married ❑ Divorced

Email Address _____ Preferred Phone # _____ Work # _____

Mailing Address _____ (Street/P.O. Box / City / State / Zip) ❑ Own ❑ Rent How long at this address _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip)

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employer _____ (If self-employed, list name of business) Occupation _____ No. Years Employed _____

Spouse/(Other) _____ (First / Middle / Last) Relationship to Patient _____

Spouse's/(Other's) Email: _____ Preferred Phone # _____ Work # _____

Mailing Address _____ (Street/P.O. Box / City / State / Zip) ❑ Own ❑ Rent How long at this address _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip)

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employer _____ (If self-employed, list name of business) Occupation _____ No. Years Employed _____

Dental Insurance Information

Policy Holder's Name _____ Insured's Soc Sec. # _____ Birthdate ____/____/____

Insurance Co. _____ Group No. _____ Subscriber No. _____

Insurance Co. Address _____ Phone No. _____

Policy Holder's Employer _____ Do you have other dental insurance? ❑ No ❑ Yes

Emergency Information

Name of nearest emergency contact not living with you _____ Phone No. _____

Address _____ (Street / City / State / Zip) Relationship to Patient _____

I understand that where appropriate, credit bureau reports may be obtained.

Parent or Guardian Signature _____ Date _____

CHILD HEALTH HISTORY

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

Y	N	**Latex Allergy**	Y	N	Heart Murmur	Y	N	Hyperactive
Y	N	Allergies	Y	N	Convulsion/Epilepsy	Y	N	Lung Problems
Y	N	Anemia	Y	N	Diabetes	Y	N	Mental Disorder
Y	N	Asthma	Y	N	Drug/Alcohol Abuse	Y	N	Nervous System Disorder
Y	N	Bleeding Disorder/Hemophilia	Y	N	Fainting	Y	N	Pregnant
Y	N	Bronchitis	Y	N	Handicap/Disabilities	Y	N	Rheumatic Fever
Y	N	Cancer/Chemotherapy	Y	N	Hearing Impairment	Y	N	Speech Disorder
Y	N	Cerebral Palsy	Y	N	Hepatitis	Y	N	Tuberculosis
Y	N	Congenital Heart Defect	Y	N	HIV/AIDS	Y	N	Tumors/Growths

Office Use Only: Doctor's Comments _____

_____

Has your child experienced any other physical or mental disorder that is not listed above? Yes ❑ No ❑

If yes, please describe: _____

Has any immediate family member had any of the above? Yes ❑ No ❑ If Yes, please describe: _____

_____

Is your child allergic to any of the following drugs:

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes ❑ No ❑ If Yes, please list: _____

Is your child presently under the care of a physician for any illness? Yes ❑ No ❑ If Yes, please list: _____

_____

List any drugs or medicines presently being taken: _____

Has your child ever been hospitalized? Yes ❑ No ❑ If Yes, please give reason and date(s) _____

DENTAL HISTORY

Reason for orthodontic consultation _____

Yes	No	
____	____	Has an orthodontist been consulted previously? Name:
____	____	Have you been informed of any missing or extra permanent teeth?
____	____	Have there been injuries to the face, mouth, or teeth?
____	____	Is there pain with chewing, yawning, or wide opening?
____	____	Has your child ever had orthodontic treatment?

Date of last dental examination _____

GROWTH DATA

Yes	No	
____	____	Do you feel your child is still actively growing?
____	____	Females: Has menstruation started? Date:
____	____	Males: Has there been a voice change or change in facial hair?

May we request release of your child's medical records? Yes ❑ No ❑

Thank you for your help. If there is any information that you feel might be of value to us during your treatment of your child, please add it here:

_____

_____

_____

Great Smiles

ORTHODONTIC SPECIALISTS

Ryan J. Haldeman, DDS, MS, PA • Stephanie S. Chambers, DDS, MS, MSD • Anthony Paul Blackman, DMD, MSD

COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

Great Smiles Orthodontic Specialists is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

1. Can confidential messages including appointment reminders, x-ray results, insurance, financials/billing or other healthcare information be left on your home answering machine or voicemail? (circle one) **YES** **NO**

   Our office sends email communications in an encrypted manner. Email and text messages are used for third party appointment information and office news. This information is not shared with solicitors.

2. Can we send emails? (circle one) **YES** **NO**
3. Can we send text messages? (circle one) **YES** **NO**
4. Please list the family member(s) or other persons with names and phone numbers. If any, whom we may inform about your appointments, labs, and x-ray results or other healthcare information, insurance, financial and billing information.

Name	Relationship to Patient	Financial	Dental Treatment
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Signature of Patient
or Personal Representative _____ Date _____

*Description of personal Representative's Authority (attach documentation if necessary) _____

_____

FOR INSURANCE PURPOSES:

PLEASE SIGN AND RETURN IMMEDIATELY

Patient's name: _____

Employee name: _____

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

AUTHORIZATION TO PAY BENEFITS TO DENTIST – I hereby authorize payment directly to the below-named Dentist of the Dental Benefits otherwise payable to me.

Great Smiles Orthodontic Specialists

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SIGNED: _____ DATE: _____

Thank you for your cooperation.

Great Beginnings

PEDIATRIC & ORTHODONTIC DENTAL SPECIALISTS

Great Smiles

IT'S ALL ABOUT YOU!

Name _____ Nickname _____ Age_____

My hobbies are _____

I have a pet_____and its name is _____

My favorite food is_____

I go to school at _____ and I'm in Grade___

What I want to be when I grow up: _____

How I feel about visiting the dentist: _____

My question(s) for the doctor: _____

_____

_____

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