Welcome to Montoya Orthodontics

1730-A Rufe Snow Dr. Keller, TX 76248 817-4BRACES www.montoyaortho.com

PATIENT INFORMATION

Date _____

Patient's First Name_____ Patient's Last Name_____ Nickname_____

Patient's Address_____ City_____ State_____ Zip_____

Patient's email_____ Patient's Phone_____

Date of Birth_____ Age_____ Gender M _____ F _____ Hobbies/Interests_____

School/Employer_____ Grade/Position_____ Work Phone _____

Reason for Consultation? _____ Has the patient been examined by an orthodontist before? _____

How did you hear about our office? _____ Family members treated in our office? _____

Dentist_____ Date of last cleaning? _____

GUARDIAN INFORMATION

Guardian's First Name_____ Guardian's Last Name_____

Guardian's Relationship to Patient _____ Phone_____

Address_____ City_____ State_____ Zip_____

Employer_____ Position _____ Work Phone_____

Date of Birth_____ Email _____

Insurance Company_____Subscriber/Member ID_____

Guardian's First Name_____ Guardian's Last Name_____

Guardian's Relationship to Patient _____ Phone_____

Address_____ City_____ State_____ Zip_____

Employer_____ Position _____ Work Phone_____

Date of Birth_____ Email _____

Insurance Company_____Subscriber/Member ID_____

SLEEP ISSUES/HABITS

Does the patient tend to be a mouth breather? ___Y ___N Does the patient snore at night? ___Y ___N

Has the patient seen an Ear, Nose & Throat Specialist? ___Y ___N Is the patient using a sleep apnea device? ___Y ___N

Please check if the patient has, or has ever had, any of the following habits?

___ Cheek, tongue, or lip chewing ___ Clenching teeth ___Grinding teeth ___Thumb sucking

___Fingernail biting ___Tongue thrusting ___Tongue sucking

MEDICAL/DENTAL HISTORY

Please check is the patient has a history of any of the following medical conditions:

___ ADHD/ADD	___ Chest Pain	___ Heart Condition	___ Osteoporosis
___ AIDS/HIV	___ Chronic Neck Pain	___ Hepatitis	___ Pneumonia
___ Acid Reflux	___ Cold Sores/Herpes	___ Immune Problem	___ Periodontal Problems
___ Anemia	___ Diabetes	___ Jaw Clicking	___ Prolonged Bleeding
___ Arthritis	___ Down Syndrome	___ Jaw Pain	___ Rheumatic Fever
___ Asthma	___ Ear Pain	___ Kidney Problems	___ Scoliosis
___ Autism	___ Emotional Disorders	___ High/Low Blood Pressure	___ Seizures
___ Bone Disorders	___ Endocrine Problems	___ Muscular Disorders	___ Sinus Problems
___ Cancer	___ Epilepsy	___ Nervous Disorders	___ TMJ Problems
___ Cerebral Palsy	___ Headaches	___ Organ Transplant	___ Tuberculosis

Have you been informed of any missing or extra permanent teeth? _____

Do your gums bleed when you brush? _____

Is the patient seeing any other dental specialist (e.g. periodontist)? _____

Any Dental restorations needing to be completed? _____

Have there ever been any injuries to the face, mouth, or chin? _____

Do you have any pain or soreness around your face, neck or back? _____

Is any part of your mouth sensitive to temperature or pressure? _____

Is the patient currently pregnant? Due date? _____

Have adenoids or tonsils been removed? If yes, when? _____

Are antibiotics necessary prior to treatment? _____

Allergies? (i.e. Drug, latex, etc.) _____

Any diseases or problems not mentioned above? List here. _____

Currently taking medications? List. _____

SIGNED CONSENT

I understand the information given is correct and will be held in the strictest of confidence. I also understand that it is my responsibility to inform this office of any changes in the patient's medical status.

I hereby authorize this office to perform an orthodontic evaluation and consent to the taking of x-rays, photographs, and other records (if necessary) to determine appropriate treatment on the above-named patient.

I also authorize this office to leave messages about appointments on my voice mail or answering machine, and agree to receive e-mail reminders and text messages about appointments.

Signature _____ Relationship to patient _____ Date _____

MONTOYA ORTHODONTICS

HIPAA 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 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Montoya Orthodontics to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
  Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.
  Additionally, I authorize you to share all my protected health information with the following individual(s):
-

Name:	Relationship:	Phone: - -
Name:	Relationship:	Phone: - -
Name:	Relationship:	Phone: - -

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 personal 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 request 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 healthcare operations, but that you are not required to agree to use 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 will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
If signing on behalf of someone, explain your relationship to the patient:	

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:
Describe your good faith effort to obtain the individual's signature on this form:

Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: / /