Benjamin D. Wright, DMD.

CHILD NEW PATIENT MEDICAL HISTORY FORM

Patient's Name: _____ Nickname: _____ Sex: M / F

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Date of Birth: _____ Age: _____ School: _____ Grade: _____

Family Dentist: _____ Family Physician: _____

Primary Orthodontic Concern: _____

Whom May We Thank for referring you to Our Practice: _____

Responsible Party Information (Please list insurance holder first)

Responsible Party #1: _____ Marital Status: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

Home #: _____ Cell#: _____ SSN#: _____/_____/_____

Employer: _____ Location: _____ Work Phone: _____

Email Address: _____

Responsible Party #2: _____ Marital Status: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

Home #: _____ Cell#: _____ SSN#: _____/_____/_____

Employer: _____ Location: _____ Work Phone: _____

Email Address: _____

In case of EMERGENCY, whom should we contact? (other than parent/guardian)

Name: _____ Phone # _____

PATIENT'S SIBLINGS:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Health Questionnaire

Is Child currently under doctor's care? Y / N Condition: _____
Current Medication reason for taking: _____
Allergies: _____
Please circle all conditions that apply to your child:

						Injury to:		
Arthritis	No	Yes	Hepatitis	No	Yes	Face	No	Yes
Diabetes	No	Yes	Kidney Disease	No	Yes	Head	No	Yes
Rheumatic Fever	No	Yes	Sleep Problems	No	Yes	Teeth	No	Yes
Heart Problems	No	Yes	Sore Throats	No	Yes			
Hemophilia	No	Yes	Pregnancy	No	Yes			
Adenoids Removed?	No	Yes	Bleeding	No	Yes			
Tonsils Removed?	No	Yes						

Dental Questionnaire

ORAL HABITS

Clenching & Grinding of Teeth:	No	Yes
Finger or Thumb Sucking:	No	Yes
When Stopped? _____		
Chewing Difficulties:	No	Yes
Speech Problems:	No	Yes
Gagging:	No	Yes

Previous Orthodontic Treatment: No Yes
Other Family Members who have had Orthodontic Treatment: _____
_____

Jaw Joint Problems:

Clicking & Popping	No	Yes
Pain	No	Yes
Facial Pain	No	Yes

Do your gums bleed: No Yes
How many times per day do you brush: _____
Do you floss: No Yes

Date of last dental visit: _____

Growth and Development

Has there been recent rapid growth No Yes
Has there been a recent decline in growth No Yes

Height _____
Weight_____

Are there any other problems, questions, or concerns not addressed on this form that you think we should be aware of?

_____

_____

Signature: _____ Parent/Guardian Date: _____

Orthodontist Signature: _____ Date_____

Dental Insurance Information Form

This form is for DENTAL coverage only. The information you provide will be used to verify your orthodontic benefit, so please fill out this form completely. As a courtesy, we are happy to file an insurance claim on your behalf once active treatment is initiated. Without this information we are unable to file your claim.

Patient Name: _____ Patient's DOB: _____

Primary Insurance Co Name: _____ Phone # _____

Insurance Co. Address: _____City _____State _____ Zip _____

Subscriber's Full Name: _____Relationship to Patient:_____ DOB: _____

Subscriber's Address: _____City _____State_____ Zip_____

Social Security # _____Subscriber ID # _____Group #_____

Employer: _____ Work Phone # _____

Secondary Insurance Co Name: _____ Phone # _____

Insurance Co. Address: _____City _____State _____ Zip _____

Subscriber's Full Name: _____Relationship to Patient:_____ DOB: _____

Subscriber's Address: _____City _____State_____ Zip_____

Social Security # _____Subscriber ID # _____Group #_____

Employer: _____ Work Phone # _____

Wright Orthodontics

HIPAA

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, to communicate with your Dentist/Dental Specialist via phone/letter/email, and to evaluate the quality of care that you receive. We may use or disclose identifiable health information about you without your authorization for several other reasons. Last names are displayed on computer screens for internal office use solely for the purpose of signing in on the check in monitor and for the doctor patient flow system. Subject to certain requirements, we may give out health information without authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights to your health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact:

Melissa Wright c/o
Benjamin Wright, D.M.D.
479 Jumpers Hole Road Suite 203
Severna Park, MD 21146
410-544-0072

Please be sure to enclose the patient and responsible parties' names.

I have received, read and understand my Health Information (HIPAA) rights.

Signature:_____ Date:_____

Patient Name:_____