New Braunfels Orthodontic Associates

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www.foundmysmile.com

NOTICE TO PARENT OR GUARDIAN

We require the presence of the patient's parent or legal guardian during the initial exam to ensure accurate understanding of the extensive information that will be provided. Thank you for entrusting Dr. Layfield with your orthodontic care.

1. *Please enter patient information:

First Name: _____ Last Name: _____ Middle Initials: _____

Date of Birth: _____ Gender: ○ Female ○ Male

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Attending School: _____ Grade Level: _____ Patients Interest & Hobbies: _____

2. *Primary Responsible Party:

Relationship to Patient:
○ Mother ○ Father ○ Step-Mother ○ Step-Father ○ Grandparent ○ Other Legal Guardian

First Name: _____ Middle Initials: _____ Last Name: _____

Gender: ○ Female ○ Male Date of Birth: _____ Marital Status: ○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Email: _____ Preferred contact method: ○ Mobile Phone ○ Email

3. *Secondary Responsible Party:

Relationship to Patient:
○ Mother ○ Father ○ Step-Mother ○ Step-Father ○ Grandparent ○ Other Legal Guardian

First Name: _____ Middle Initials: _____ Last Name: _____

Gender:
○ Female
○ Male

Date of Birth: _____

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated
○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Email: _____

Preferred contact method:
○ Mobile Phone ○ Email

4. *Responsible Parties Employer:

Responsible Party	Employer Name	Occupation
Primary		
Secondary (optional)		

5. *Other family members:

Name and age of additional children in the family:

_____

_____

Are any family members active or previous patients of Dr. Layfield?
○ Yes ○ No

If yes, please list patients name:

_____

6. *How did you hear about our office?

○ Dentist Referral ○ Family/Friend Referral ○ Google Search
○ Community Event

Please name either the Dentist or Family/Friend that referred you; If you met us at a community event please tell us which one.

_____

7. *General Dentist Information:

Have you had a dental visit in last 6 months?
○ Yes ○ No

Dentist Name: _____

8. *What treatment option(s) is the patient interest in?

☐ Invisalign ☐ Traditional Braces ☐ Retainers

INSURANCE STANDARD

We ask that you realize we don't work for an insurance company, but we do work 100% for our patients. Most insurance companies provide great benefits for our patients and we're going to do everything we can to maximize your benefits. Please understand that the fees we charge and the treatment that we're going to recommend is specifically designed for your individual needs and never based on your insurance coverage.

9. *Do you have Orthodontic Insurance?

○ Yes ○ No

If yes, please complete the Dental Insurance section below

10. Primary Dental Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Policy Holder First and Last Name _____ Patient Relationship to Insured ○ Self ○ Child ○ Other

Insured Date of Birth _____ Policy Holder Employer _____

Insured Street Address _____ City _____ State _____ Zip Code _____

Insured Contact Number _____

11. Secondary Dental Insurance (optional)

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Policy Holder First and Last Name _____ Patient Relationship to Insured ○ Self ○ Child ○ Other

Insured Date of Birth _____ Policy Holder Employer _____

Insured Street Address _____ City _____ State _____ Zip Code _____

Insured Contact Number _____

12. Has your child had previous orthodontic treatment?

○ Yes ○ No

13. *What is your primary concern(s)?

_____

14. *Patient History

Has the patient reached puberty?
○ Yes ○ No

Please list any medication the patient is currently taking

Does the patient have any allergies? If yes, please list below

15. Check if your child has or has had any of the following:

- ☐ Anemia
- ☐ Asthma/COPD
- ☐ Bleeding abnormally
- ☐ Cancer Treatment
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ GERD/Acid Reflux
- ☐ Headaches/Migraines
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV AIDS
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Tobacco use

Other/Details:

16. Indicate any history of (check all that apply); If checked "Yes", please explain.

- ☐ Thumb/finger sucking
- ☐ Tongue and/or swallowing problems
- ☐ Speech problems
- ☐ Loose teeth or broken fillings
- ☐ Grinding and/or clenching of teeth
- ☐ Tonsils and adenoids removed
- ☐ Crowns/Bridges
- ☐ Root canals
- ☐ Mouth breathing
- ☐ Snoring
- ☐ History of wearing a mouthguard at night
- ☐ History of Periodontal disease
- ☐ History of Periodontal treatment
- ☐ Mouth sores
- ☐ Injury to face or teeth
- ☐ Jaw Pain
- ☐ Clicking or popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ Sensitivity when biting
- ☐ Cold, hot, or sweets sensitivity certain teeth
- ☐ Food collection between

Other/Details:

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

Signature

Date

New Braunfels Orthodontic Associates FoundMySmile.com

Larry L. Layfield, D.D.S.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

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 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 contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to 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 is not affected.

Date:

Patient Name:

Relationship to Patient:

Signature:_____