WELCOME TO THE ORTHODONTIST

Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____ ☐ M ☐ F
LAST FIRST MI

Birthdate: ___/___/___ Age: _____ SS #: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home # (_____) _____

Child's Home Address: _____

_____
CITY STATE ZIP

E-mail Address: _____

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

List other family members seen by us _____

_____

General Dentist: _____

Date of last cleaning / visit: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

3 Parental Information

☐ **Mother** ☐ Stepmother ☐ Guardian

Name: _____ Birthdate ___/___/___

Wk # (_____) _____ Hm # (_____) _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____ DL #: _____

☐ **Father** ☐ Stepfather ☐ Guardian

Name: _____ Birthdate ___/___/___

Wk # (_____) _____ Hm # (_____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Previous Address: _____

_____
CITY STATE ZIP

Hm # (_____) _____ DL #: _____

Employer: _____

Wk # (_____) _____ SS #: _____

Who is responsible for making appointments?

Name: _____ Wk # (_____) _____

Cell # (_____) _____ Hm # (_____) _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Pplicy Owner's Employer: _____

Employer's Address: _____

CONTINUED ON BACK

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What would you like orthodontics to accomplish?

Has your child ever taken Phen-Fen? (Redux or Pondimin) If yes, when? ☐Y ☐N

Has your child ever been evaluated or had orthodontic treatment before? ☐Y ☐N

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐Y ☐N

Has your child been informed of any missing or extra permanent teeth? ☐Y ☐N

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐Y ☐N

Does your child brush his / her teeth daily? ☐Y ☐N

Does your child floss his / her teeth daily? ☐Y ☐N

Child's Physician: _____

Phone # (_____)_____ Date of last visit: _____

Is your child under the care of a physician? ☐Y ☐N

Has puberty begun? ☐Y ☐N

Girls - Has menstruation begun? ☐Y ☐N

Please describe your child's current physical health: ☐Good ☐Fair ☐Poor

Please list all drugs that your child is currently taking:

_____ _____

Please list all drugs/things that your child is allergic to:

_____ _____

Latex Y N Metals/Nickel Y N Plastics Y N

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

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to Any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones / Joints	Y	N	HIV+ / AIDS
Y	N	Artificial Valves	Y	N	Kidney / Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

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Has your child ever experienced any of the following?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing / Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Neighbor or Relative not living with you

Name _____ Ph # (_____)_____

Address _____

_____

CITY STATE ZIP

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

I authorize the dental staff to perform the necessary dental services that my child may need.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

_____

SIGNATURE OF PARENT OR GUARDIAN DATE

The Parent or Guardian who accompanies the child is responsible for payment.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____ Initials: _____ Date: _____

_____

_____

_____

Saxe ORTHODONTICS
Dr. Alana Saxe

702-541-7070
info@saxeortho.com

3555 S. Town Center Dr #104
Las Vegas, NV 89135

PRIVACY CONSENT

This form is optional under the new patient privacy regulations 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 name, dates, phone/fax numbers, email addresses, home addresses, social security numbers and demographic date) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance review, certifications, accreditations and licensure).

You have the right to review our office privacy notice prior to signing this consent, a copy of which was given to your with this consent.

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 to this consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____
Patient's Name

_____
Responsible Party's Signature

_____
Date

Please see and initial other side)

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 carefully!

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

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with out rendering orthodontic treatment to you (i.e., to determine the 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 payments of your account (i.e., to determine benefits, dates of payments, etc.)
- To certifying, licensing, and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certifications, licensures or accreditations
- 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, scheduling, etc.
- To your family and close friends involved in 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 of 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 protected 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 inquires to our Privacy Contact Person at our office address) or 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 setting forth our legal duties and privacy practices with respect to such information
- To abide by the terms of our Privacy Notice that is currently in effect
- To advise you of our rights 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 of disclosure of your health information
- Amend your protected health information if, for example, it is accurate and complete
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overhead 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.

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

Initials _____

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Consent Form for Radiographs and Photographs in Our Office

Welcome to Saxe Orthodontics! During your initial consultation we will take a series of photographs and possibly a 3-D digital radiograph for diagnostic purposes.

Dr. Saxe will then complete a comprehensive oral exam and use these images to understand your concerns and explain orthodontic treatment options.

Radiographs:

( ) Yes, I consent to having x-rays taken at Saxe Orthodontics.

( ) No, I refuse x-rays at this time.

Photographs:

( ) Yes, I consent to having photographs taken at Saxe Orthodontics.

( ) No, I refuse photographs at this time.

*Radiographs and photographs are intended for diagnostic purposes within our office. You may order a digital copy of records (photos, panorex, & cephalometric images) at any time for a processing fee of $195. Please allow 10 days for processing.

_____
Print Name of Patient

_____
Print Name of Responsible Party

_____ _____
Signature of Responsible Party Date