408 W Oak St, El Dorado, AR 71730
Phone: 870-639-1737 Fax: 870-639-1732

1912 Lamy Ln, Monroe, LA 71201
Phone: 318 600-3040 Fax: 318 600-6987

YOU MUST BE AT LEAST 18 YEARS OLD TO SIGN THESE FORMS

Patient Information

First Name_______________ Last Name_________________ Home Phone_________________ Cell Phone______________
Mailing Address_____________________________________ City, State_____________________ Zip_________________
Physical Address_____________________________________ City, State_____________________ Zip_________________
Date of Birth______________________ Social Security #_______________________ Employer________________________
Emergency Contact(not parent or patient) _____________________ Relationship to Patient_________ Phone__________
Are you now or have you recently been under a physician's care?____
Dentist____ Date of last dental exam_______________

Parent, Legal Guardian or Spouse Information

Name_______________________ Date of Birth ________________ Social Security #______________________________
Employer_______________________________ Employer Phone____

HOW DID YOU HEAR ABOUT US?____

Patient's Medical History

Please circle any of the following that you have had, now or in the past:

Birth Defects or hereditary problems
Arthritis or joint problems
Cancer, tumor, radiation treatment
Chemotherapy
History of Osteoporosis
Gonorrhea, syphilis, herpes, STDs
Seizures, fainting spells, neurologic problems
Vision, hearing, or speech problem
High or low blood pressure
Heart defects, heart murmur
Rheumatic heart disease
Frequent headaches, migraines
Hay fever

Bone fractures or major injuries
Endocrine or thyroid problems
Kidney problems
Immune system problems
AIDS or HIV Positive
Polio, mononucleosis, tuberculosis
Pneumonia
Eating disorder (anorexia, bulimia)
Excessive bleeding, bruising, or anemia
Angina, arteriosclerosis, stroke
Tire easily, swollen ankles
Frequent ear infections, colds
Throat infections

Injuries to head, face, neck
Diabetes or low sugar
Stomach ulcer, hyperac idity
Acid Reflux
Hepatitis, jaundice
Other liver problems
Mental health disturbance
Depression
Chest pain, shortness of breath
Heart attack
Skin disorder (other than acne)
Asthma, sinus problems
Tonsil or adenoid condition

Do you eat a well-balanced diet?________ Do you frequently breathe through your mouth?_________
Have you had allergies or reactions to any of the following? (Please circle)
Local anesthetics (Novocain, Lidocaine, Xylocaine), latex (gloves, balloons), aspirin, metals (jewelry, clothing snaps), Penicillin, other antibiotics, ibuprofen (Motrin, Advil), acrylics, plant pollens, animals, foods, other______________________
List medications you are currently taking, if any: ____
Women only: Are you pregnant?________

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Patient's Dental History

Circle any of the following that you have had, now or in the past:

Permanent or extra teeth removed
Sensitive or sore teeth
Jaw fractures, cysts, infections
Frequent canker sores or cold sores
Difficulty breathing through nose
Oral habits (thumb sucking, chewing pen, etc)
Teeth causing irritation to lip, cheeks, gums
Soreness in jaw or face muscles
Broken or missing fillings

Extra or congenitally missing teeth
Bleeding gums, bad taste, mouth odor
Root canals or pulpotomies
Speech problems, speech therapy
Mouth breathing habit
Abnormal swallowing (tongue thrust)
Clicking, locking in jaw joints
Difficulty chewing or opening jaw

Chipped or injured primary or permanent teeth
"Gum boils"
Food impaction between teeth
Snoring at night
Tooth grinding, clenching
Ringing in ears
TMJ or TMD problems

Have you traveled to West Africa in the last 24 months?____
Have you ever been diagnosed with gum disease or pyorrhea?____
Have you ever had an orthodontic consultation or treatment before now?____
What concerns you most about your teeth?____

Release and Waiver

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature ____ Date__________

I authorize the release of any information regarding my orthodontic treatment to my insurance company.

Signature ____ Date___________

ATTENTION: If patient is under age 18, a legal guardian must sign this form for the patient.

Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; obtain payment from third party payers; and conduct normal healthcare operations such as quality assessments and physical certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to my signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of *the Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature ____
Relationship to Patient_____________________________
Date____

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Additional Information Required for Billing Party

Responsible Party____

Responsible Party's Address____

City, State Zip____

Home Phone #____ Cell #____

Responsible Party's Social Security #____________________________________ Responsible Party's DOB__________________

Responsible Party's Place of Employment____

Employment Phone #____

Spouse's Name___________________________ Spouse's Social Security #_____________________DOB___________________

Spouse's Place of Employment____

Employment Phone____

Sibling Information

Brother/Sister's name____

Birth Date__________________ Has he/she ever been referred to an orthodontist?___________________________________

Brother/Sister's name____

Birth Date__________________ Has he/she ever been referred to an orthodontist?___________________________________

Brother/Sister's name____

Birth Date__________________ Has he/she ever been referred to an orthodontist?____________________________________

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THIRD PARTY AUTHORIZATIONS

I, ____________________________, am the legal guardian of ____, (patient) and give the following individuals permission to bring my child to any appointments at Williams Orthodontics. I also give Williams Orthodontics permission to discuss with the following individuals anything pertaining to my child's treatment.

1.____

2.____

3.____

4.____

5.____

Legal Guardian's printed name______________________________

Legal Guardian's signature_____________________________Date_________