Today's Date: ____________
MM/ DD/ YYYY

PATIENT

Patient's Last Name_____________________First Name______________________
Preferred Name________________Birth Date _____________
MM / DD / YYYY
Home Address____
STREET CITY STATE ZIP
Child's School___________________________Grade________
Child's Cell Phone_________________Child's Cell Provider (used for text messaging reminders)_____________
Child's Email ____
How did you hear about our office?_____________________________
If referred by a patient/friend, whom may we thank?_________________________

GENERAL INFORMATION

What concerns do you have about your child's teeth?____
How do you feel about Orthodontic Treatment?____
Have any other family members had Orthodontic Treatment?_______________________________________
Does the patient have any siblings? Names and Ages?____
Has your child had a previous orthodontic examination? ____
If yes, what was the reason for not starting treatment?____
Your child's favorite hobbies and activities____

DENTIST

Patient's Dentist____City, State_______________
Last Appointment_____________Reason____
Is there any dental treatment planned? ____

RESPONSIBLE PARTY #1

Name______________________________________Relationship to Patient ___________________________
Home Address____
STREET CITY STATE ZIP
Cell Phone___________________Email____
Preferred Method of Contact______________Financially Responsible ☐ yes ☐ no

If not the financially responsible party, please fill out the information below:

FINANCIALLY RESPONSIBLE PARTY

Name_____________________________________Relationship to Patient_____________________________
Home Address____
STREET CITY STATE ZIP
Cell Phone__________________Email____

DENTAL INSURANCE

Orthodontic Coverage? ☐Yes ☐ No ☐Unsure

Primary Insurance Co.________________________________Employer_____________________

Primary Policy Holder_______________________Birth Date _____________
MM / DD / YYYY

ID#____Group #___________________________

Secondary Insurance Company_______________________Employer_____________________

Policy Holder______________________________Birth Date ___________
MM / DD / YYYY

ID#______________________________Group #______________________________

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Electronic Signature ____________________________________

Date ____________
MM / DD / YYYY

Your Experience

We want to make orthodontic treatment a great experience for you and your family. Please list your top two priorities during treatment from the list below so we can help personalize your experience.

Time in the office, Cost, Esthetics, Number of Visits, Hygiene

First Priority: ____

Second Priority: ____

kirkland ORTHODONTICS

DENTAL HISTORY

Have you been informed of your child missing or having extra permanent teeth? ☐Yes ☐No
Chipped or Injured primary or permanent teeth? ☐ Yes ☐ No
Injuries to the: ☐Face ☐Mouth ☐Chin
Does your child brush daily? ☐Yes ☐No Floss? ☐Yes ☐No
Does your child have any of the following:

Lip/thumb sucking	☐	Pacifier after age 3	☐	Snoring		Mouth breather	☐
Difficulty closing lips	☐	Chew hard objects	☐	Grind teeth		Sleep Apnea	☐
Bite/chew nails	☐	Speech problems	☐	Clench jaw		Tongue thrust	☐

MEDICAL HISTORY

Has the patient had and/or have any of the following:

Tonsils removed	☐	Snoring	☐	Herpes	☐	Joint replacement or implant	☐
Adenoids removed	☐	ADD/ADHD	☐	AIDS, HIV positive	☐	Heart defect, disease or murmur	☐
Sleep apnea	☐	Latex allergy	☐	Hepatitis	☐	Fainting spells, seizures	☐
Asthma	☐	Nickel allergy	☐	Diabetes	☐	Scarlet fever, rheumatic fever	☐

List any known allergies____
Is your child taking any medications?______If yes, please list________________________________
Are your child's immunizations up to date? ______
If female, has the patient begun menstruating?______
Is your child pregnant or could be pregnant?______
Any other disease, condition or problem not listed that you think we should know about?
____

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 made in my child's medical or dental health.

Parent/Guardian Electronic Signature ________________________________
Date __________
MM / DD / YYYY

EMERGENCY CONTACT (PERSON NOT LIVING WITH PATIENT)

Name: ________________________ Relationship to Patient: _____________________________
Home Address: ____
STREET CITY STATE ZIP
Cell Phone ________________________ Email _______________________________________

AUTHORIZATION AND CONSENT TO SEND UNENCRYPTED PATIENT INFORMATION AND OTHER ELECTRONIC MEANS

I authorize Kirkland Orthodontics to transmit patient information relating to my child's treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my child's treatment, payment for treatment, or Kirkland Orthodontics health care operations. The patient information may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- *I do not have to sign this form.*
- *My child's treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.*
- *If I don't sign this form, Kirkland Orthodontics may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.*
- *Kirkland Orthodontics does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.*

I can tell you in writing to stop emailing my child's patient information at any time, but if I do so, this will not affect emails that Kirkland Orthodontics already sent before receiving my written instructions to stop.

Patient Electronic Signature ___________________________________

Date ___________

MM / DD / YYYY