

Date: _____

Child Welcome Information

Patient's Name _____ Nickname _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Date of Birth _____ SSN _____

School _____ Grade _____ Hobbies or special interests? _____

Are there siblings? (names/ages) _____ Dentist _____

Whom may we thank for referring you to our office? (Check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Dentist _____ | <input type="checkbox"/> Mansfield Cares _____ | <input type="checkbox"/> Mansfield ISD Education Foundation _____ |
| <input type="checkbox"/> Friend/Family/Neighbor _____ | <input type="checkbox"/> Miles for Meredith _____ | <input type="checkbox"/> Feed the Kids _____ |
| <input type="checkbox"/> Internet (Where specifically?) _____ | <input type="checkbox"/> School Field Trip _____ | <input type="checkbox"/> Location _____ |
| <input type="checkbox"/> Other _____ | | |

What are the main concerns that you would like orthodontics to accomplish? _____

Dental Status

When was the patient last seen by the dentist? _____

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Has the patient had previous orthodontic treatment or consultation? When? Why? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Has any member of the family had orthodontic treatment? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Has the patient had any trouble associated with dental treatment? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Has the patient had any teeth extracted? Why? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Has the patient ever injured or broken any teeth? When and what happened? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Has the patient ever injured the head or face? When and what happened? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient have any missing or extra teeth? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient have any problem with eating, chewing, or swallowing? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient suck thumb, fingers, tongue, blanket, or pacifier? (circle which) _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient have any dental or facial pain? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient's jaw joint make noises or hurt when opening, closing, or chewing? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient habitually grind or clench the teeth together? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient normally breathe with the lips parted? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is the patient aware of any swellings or growths in the mouth or face? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient have negative or resistant feelings about orthodontic treatment? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is the patient especially concerned about orthodontic treatment? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is the patient dissatisfied with the appearance of the teeth? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is the patient especially resistant to: <input type="checkbox"/> Braces <input type="checkbox"/> Headgear <input type="checkbox"/> Retainers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is there any other information we should know? _____ |

Medical History

Please list any:

Serious illness or condition _____

Allergies or known drug sensitivity _____

Current medical care _____

Current medications _____

Tonsils and Adenoids: Present Removed at age _____

Yes No Does the patient have frequent colds or ear infections?

Has the patient ever been diagnosed or treated for the following (Check all that apply.):

- | | | | | |
|--|--|------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Endocrine Disorders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> AIDS or HIV+ |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Diabetes |

Responsible Party Information

Name _____ Relationship to Patient _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Rent or Own? _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

SSN _____ Date of Birth _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____

Employer _____ Occupation _____ No. Years Employed _____

Employer's Address _____
Street City State Zip

Spouse's Name _____ Relationship to Patient _____
Last First Middle

SSN _____ Date of Birth _____

Work Phone _____ Cell Phone _____ E-mail _____

Employer _____ Occupation _____ No. Years Employed _____

Employer's Address _____
Street City State Zip

A B C

Insurance Information

Insured's Name _____ Relationship to Patient _____
Last First Middle

Insured's Mailing Address _____
Street City State Zip

Insured's SSN _____ Insured's Date of Birth _____ Home Phone _____ Work Phone _____

Insurance Company _____ Group No. _____ Local No. _____ Employer _____

Insurance Co. Address _____
Street City State Zip

Insurance Co. Phone _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Relationship to Patient _____
Last First Middle

Insured's Mailing Address _____
Street City State Zip

Insured's SSN _____ Insured's Date of Birth _____ Home Phone _____ Work Phone _____

Insurance Company _____ Group No. _____ Local No. _____ Employer _____

Insurance Co. Address _____
Street City State Zip

Insurance Co. Phone _____

Signature of Responsible Party

To the best of my knowledge, the information given is correct. Furthermore, I understand that it is my responsibility to inform this office of any changes in this patient's medical status or insurance information. I authorize Dr. Herrmann to perform a complete orthodontic evaluation including digital photos and 3D digital x-rays. I also understand that diagnostic records and name may be used in educational and promotional purposes. I also understand that in order to receive complete information on financial options, credit bureau reports may be obtained.

Signature: _____ Relationship to Patient: _____ Date: _____



About iCat® CBCT Cone Beam Scans

Rick Herrmann Orthodontics offers an exciting technology for our patients. This technology is iCat® Cone Beam Computer Computed Tomography (CBCT) imaging, sometimes called 3-D radiographs or x-rays. Using CBCT means we have the ability to take 3D images of the teeth, jaws, bones and facial structures at lower costs and with less energy than a typical CT scan used in hospitals. 3D imaging provides us the opportunity of improved diagnosis for our patients, especially in cases of impacted teeth, dental implants, surgical treatment, as well as more complex cases. Understandably you may have questions about exposure to these types of x-rays. Here are some facts you should know about 3-D imaging. An **iCat® CBCT (@8.5 seconds) exposure is;**

- About ½ as much as a full series of digital dental images
- About 1/5 as much as a full (28) mouth series of standard dental x-rays
- About 1/70 as much as a typical medical CT scan.

CBCT therefore offers our patients enhanced diagnostic value at significantly reduced exposure. At the same time, CBCT scans can image the entire head and most of the neck. As dentists and orthodontists, we evaluate teeth, jaws and surround supporting bone using CBCTs for those limited purposes. Our training and dental license does not provide for evaluating and diagnosing outside those areas. However since CBCT imaging can cover a broader area, we want to offer you the opportunity to have your CBCT scan read by an oral radiologist, trained and licensed to evaluate and diagnose a broader area. CBCT may show evidence of disease of the cervical spine, skull or arteries. We can refer you to a radiology group for this purpose.

() Yes, I want to have the iCat® CBCT scan(s) read by an oral radiologist and understand that there is an **additional fee of \$250.00 that must be paid prior to having each scan sent out to be read.**

() No, I understand the risks and benefits of having CBCT scan(s) read and interpreted by an oral radiologist, however I knowingly decline such a referral.

Signature of responsible party

Date



RICK HERRMANN ORTHODONTICS, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Patient's Name

Signature of Patient or Parent/Guardian

Relationship to Patient, If **Not** the Patient

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual or Parent/Guardian refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-
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