Timothée ORTHODONTICS

FOR CHILDREN: WELCOME TO OUR PRACTICE

Janice Timothée, DMD
900 Spivey Road • Whiteville, NC 28472
P. 910.642.4529
www.timotheeorthodontics.com

1. TELL US ABOUT YOUR CHILD

Today's date: ______ DOB: ______

Child's Name: Age: ______

First Middle Last

Preferred Name: ______ ☐ Male ☐ Female

School: ______ Grade: ______

Home#: ______ Cell#: ______

Email: ______

Hobbies / Special Interests: ______

Mailing Address

City State Zip

Siblings:

Name: ______ Age: ______

Name: ______ Age: ______

2. WHO IS WITH THE CHILD TODAY?

Name: ______

Relation: ______

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

Who may we thank for referring you? ______

Other family members seen by us: ______

Previous/Present Dentist: ______

Street: ______

Phone #: ______ Last Visit: ______

Parent's Marital Status: ______

(Single, Married, Divorced)

3. MOTHER'S INFORMATION

Name: ______ Cell#: ______

WK#: ______ Home#: ______

Employer: ______

4. FATHER'S INFORMATION

Name: ______ Cell#: ______

WK#: ______ Home#: ______

Employer: ______

5. RESPONSIBLE PARTY INFO

Name: ______

Billing address : ______

City State Zip

WK#: ______ Home#: ______

Cell#: ______

Email: ______

Employer: ______

6. PRIMARY DENTAL INSURANCE

Ins. Name: ______

Ins. address : ______

Insurance Co. Phone #: ______

Group/Policy # : ______

Insured's Name: ______

Relationship to Patient: ______

Insured's DOB: ______

Insured's Employer: ______

SS#: ______

Orthodontic Coverage ☐ Yes ☐ No

7. SECONDARY DENTAL INSURANCE

Ins. Name: ______

Ins. address : ______

Insurance Co. Phone #: ______

Group/Policy # : ______

Insured's Name: ______

Relationship to Patient: ______

Insured's DOB: ______

Insured's Employer: ______

SS#: ______

Orthodontic Coverage ☐ Yes ☐ No

8. DENTAL HISTORY

Has the child ever had a serious/difficult problem associated with dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush teeth daily? ☐ Yes ☐ No

Floss their teeth daily? ☐ Yes ☐ No

Is the child currently under the care of a physician? ☐ Yes ☐ No

Explain: ____________________

Child's Physician: ____________________

Phone #: ____________________ Last Visit: ____________________

Please describe the child's health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs the child is currently taking: ____________________

Please list all drugs the child is allergic to: ____________________

9. HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment
☐	☐	HIV+/AIDS	☐	☐	Any Operations
☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis	☐	☐	Allergies to Any Drugs
☐	☐	Prosthesis	☐	☐	

Please discuss any serious medical problems that the child has had:

10. DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Yes	No		Yes	No	
☐	☐	Thumb sucking / Finger sucking	☐	☐	Nail Biting
☐	☐	Lip sucking / biting	☐	☐	Nursing Bottle Habits

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

11. I understand 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.

Signature of parent/guardian_____________________________________ Date:____________________________

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

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

Initials: ______________________ Date:______________________

Doctor 's comments:______________________________________

____

Medical History Update:

1. Date:_______________ Signature:___________________

Comments:____

1. Date:_______________ Signature:___________________

Comments:____

Timothée ORTHODONTICS

Janice Timothée, DMD
900 Spivey Road • Whiteville, NC 28472
P. 910.642.4529
www.timotheeorthodontics.com

Authorization for Release of Information – Compound Release

Name of Patient ____ Date of Birth _____________

____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other__________________________
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* ______________________________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * ______________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: ______________________________
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____________________________

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____Date _________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

____

Revised Oct 2014

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

Practice Name: Timothée Orthodontics ______________________________

Patient Name: ____

Parent/Guardian Name (if applicable): _____________________________

Address: ____

____

Phone: ____

I have received a copy of the Notice of Privacy Practices for the above named practice.

____________________________________ ______________

Patient/Parent Signature Date

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed and a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: