Drs. Callahan Flanagan Smith & Stock
ORTHODONTICS
WEBSITE: www.cfsbraces.com

Date: _____

Patient Name: _____Nickname: _____

Mailing Address: _____City/State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____ Social Security # _____

Home # _____ Cell # _____Work # _____ E-mail Address: _____

Student: Full time _____ Part time _____ School Name_____

Musical Instrument: _____Sports: _____Other Interests:_____

DENTIST: _____

RESPONSIBLE PARTY: Self___Father ___ Mother ___ Step parent___ Other___ Single __ Married __Divorced __

Name: _____Date of birth:_____ Social Security # _____

Home # _____ Cell#_____ Work # _____E-mail _____

Home address: _____ City & State: _____ Zip: _____

Employer: _____Number of years employed: _____ Occupation:_____

RESPONSIBLE PARTY: Father___ Mother___ Step parent ___ Other___ Single __ Married __Divorced __

Name: _____Date of birth: _____ Social Security # _____

Home # _____ Cell#_____Work # _____ E-mail _____

Home address: _____City & state: _____ Zip: _____

Employer: _____Number of years employed: _____Occupation:_____

PERSON FINANCIALLY RESPONSIBLE (if other than parent) _____

Address: _____ Phone: _____

PERSON TO CONTACT IN CASE OF EMERGENCY _________Phone:_____

DENTAL INSURANCE INFORMATION

Name of PRIMARY insurance company: _____ Telephone # _____

Insurance company address: _____

Name of policy holder_____ Relationship to patient_____

Employer: _____ Social Security#_____

Date of birth: _____ ID # _____ Group# _____

Name of SECONDARY insurance company: _____Telephone # _____

Insurance company address: _____

Name of policy holder: _____Relationship to patient_____

Employer: _____Social security#_____

Date of Birth: _____ ID # _____ Group# _____

****HOW DID YOU HEAR ABOUT OUR PRACTICE?****

☐ One of our staff members ☐ Dentist ☐ Another Patient ☐ Internet ☐ Other_____

MEDICAL INFORMATION

Name of Physician_____Last Visit_____

PLEASE CHECK IF PATIENT HAS OR HAD

Normal Weight/Height	☐	Recent Dental Exam	☐	Allergic to Nickel	☐
AIDS	☐	Downs Syndrome	☐	Malignancies	☐
Anemia	☐	Emotional Disorders	☐	ADD/ADHD	☐
Arthritis	☐	Epilepsy/Seizures	☐	Prolonged Bleeding	☐
Autism	☐	Fainting/Dizziness	☐	Diabetes	☐
Bulimia	☐	Heart Condition	☐	Rheumatic Fever	☐
Cancer	☐	Hepatitis	☐	Scarlet Fever	☐
Cerebral Palsy	☐	High Blood Pressure	☐	Tonsils/Adenoids Removed	☐
Chest Pain	☐	Immune Problems	☐	Tuberculosis	☐
Cold Sores/Herpes	☐	Kidney Problems	☐	Sexually Transmitted Infection	☐
Chew/Smoke Tobacco	☐	Allergy to Latex	☐	Low Blood Pressure	☐

Are you currently taking medications for osteoporosis, i.e. Bisphosphonates? Y N

List any medications you currently take:_____

_____

List any disease, problems or allergies not mentioned:_____

Is patient currently pregnant? Y N If so, how far along?_____

Has a physician ever advised antibiotics before a dental exam?_____

Dental History

Last Visit with your dentist:_____

Any restorative work needed? Y N If so, please explain:_____

Has your dentist pointed out any orthodontic issues? Y N If so, what?_____

Have you visited an orthodontist before? Y N If so, when?_____

Injuries to face or mouth? Y N Please Explain_____

Any history of thumb/finger habit? ☐ Mouth Breathing ☐ Grinding/Clenching ☐ Tongue Thrust ☐

Any Speech Issues? ☐ Pain, clicking or discomfort in jaw area? ☐ Describe_____

Have you been informed of missing or extra permanent teeth? Y N

Are you aware of any gum problems? Y N Have you ever been advised to see a periodontist? Y N

Have we treated any other family members? Y N

Please list:_____

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.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that 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/orthodontic services my child or myself may need.

_____

Signature of Parent, Guardian or Patient (over the age of 18) Date

ACKNOWLEDGEMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practice and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

_____

Signature of Parent, Guardian or Patient (over the age of 18) Date

PHOTO RELEASE

I, _____ consent to and authorize the use of my/my child's/or any other minor in my care's photographs by Callahan, Flanagan, Smith, and Stock Orthodontic Practice. I understand these photographs can be used in both printed and electronic format (The CFS&S Website, Facebook page, etc.) I also understand that when this material is used, last names will not be posted publicly.

Signature_____ Date _____

Name and age if minor:

Name_____ Age _____