Benedetti Orthodontics
Health History Form - Child

Patient Information

Patient's Name:_____ Age:_____ Birth date:_____

Name you like to be called:_____ School: _____ Grade:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone# _____ Cell Phone # _____Social Security #:_____

Email: _____ Who may we thank for referring you to our office?_____

Parent/Legal Guardian Information

*Name: _____Home Phone# _____ Cell Phone # _____

Address:_____ City:_____ State:_____ Zip:_____

Time at this residence: _____ Marital Status: _____ Relationship to patient: _____

Social Security #: _____ Birth date:_____ Email: _____

Employer: _____ Occupation:_____ No. of years employed:_____

*Name: _____ Home Phone# _____ Cell Phone # _____

Address:_____ City:_____ State:_____ Zip:_____

Time at this residence: _____ Marital Status: _____ Relationship to patient: _____

Social Security #: _____ Birth date:_____ Email: _____

Employer: _____ Occupation:_____ No. of years employed:_____

Dental Insurance Information – Please Provide All Information In Order To accurately verify Ins. benefits

Insured Name: _____ Insured's SS#:_____ Insurance Co:_____

Insurance member id:_____ Group #:_____

Insurance Co. Address:_____

Phone:_____ Insured's Employer:_____

Do you have dual coverage? ☐Yes ☐No If yes: Insured Name: _____Insured SS#_____

Insured member id:_____ Group #: _____ Insurance Co: _____

Insured's Employer:_____ Insurance Co. Address:_____

Medical/Dental History

Physician's Name:_____ Phone:_____

Dentists Name: _____ Phone:_____

☐Yes ☐No Are you currently under any medical treatment? If So What Kind?_____

☐Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw?

☐Yes ☐No Are you aware of either clenching or grinding of teeth? History of Night Guard? ☐yes ☐no

☐Yes ☐No Do you have frequent headaches? How often?_____

☐Yes ☐No Do you have ear problems? (Aches, ringing, dizziness, fullness)

☐Yes ☐No Do you have difficulty breathing through the nose?

☐Yes ☐No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?

☐Yes ☐No Do you have speech problems, or are you in speech therapy?

☐Yes ☐No Have you had your tonsils and/or adenoids removed?

☐Yes ☐No Has there been any history of: ☐Joint swelling ☐Asthma ☐TB ☐Aids ☐HIV ☐Kidney ☐Liver Condition ☐Epilepsy ☐Rheumatic fever ☐Other major illnesses? _____

☐Yes ☐No Do you bleed easily? Anemic: ☐yes ☐no

☐Yes ☐No Is there a tendency to faint or become dizzy?

☐Yes ☐No Do you have allergies? (LATEX, Sulphur, penicillin, novocaine, etc.)_____

☐Yes ☐No Are you currently taking any medication? List:_____

☐Yes ☐No Has there been a history of growth hormone therapy? If so when and how long? _____

☐Yes ☐No Do you have a heart condition? Do you pre-medicate? ☐Yes ☐No Cardiologist:_____

☐Yes ☐No Are you currently pregnant? If yes, what is the due date? _____

Date of first menstrual cycle: _____

☐Yes ☐No Have you been diagnosed with sleep apnea? If so do you use CPAP machine? ☐Yes ☐No

☐Yes ☐No Do you smoke or chew tobacco? Quantify Usage: _____

☐Yes ☐No history of facial trauma or injuries to the teeth? Explain _____

☐Yes ☐No Have you had any permanent teeth, other than wisdom teeth, extracted? _____

☐Yes ☐No Have we treated any other family members? Who: _____

Any other medical concerns not listed above: _____

Signature: _____Date: _____

Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities with your insurance company.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of treatment, payment activities, and healthcare information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Benedetti Orthodontics
2626 East Commercial Blvd #1
Fort Lauderdale, FL 33308
(954) 771-0902

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Check box that applies:
☐**Consent:** I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to use and disclosure of my protected health information to carry out treatment and payment activities, health care operations, and **in the event of a medical emergency**.

☐**Revocation of Consent:** I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this Notice of Revocation. **I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.**

Signature of Responsible Party_____**Date**_____

Assignment and Release

I hereby authorize payment directly to ***Benedetti Orthodontics*** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____**Date**_____

Initial Exam - records

I understand that radiographs and photos will be taken during the Initial Exam for diagnostic purposes to provide an accurate treatment plan and are property of Benedetti Orthodontics. There will be a charge for any copy of said records with payment due prior to release. I further understand that I am not obligated to treatment with ***Benedetti Orthodontics*** by agreeing to these records.

Signature of Responsible Party_____**Date**_____