
**PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE**

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birth date_____ Social Security # _____

School_____Grade _____ Sports/Hobbies _____

Patient's email: _____Patient's Cell Phone_____

Parent or guardian name _____

Whom may we thank for referring you to our office? _____

**RESPONSIBLE PARTY INFORMATION**

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Previous Address (If less than 3 years) _____

Social Security #_____ Birth date_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____Birth date_____Work Phone_____

**DENTAL INSURANCE INFORMATION**

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

## EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

## MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____

**Female Patients only (used to determine the amount of growth remaining):**
Yes No Has menstruation started, and if so, month/year? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

## DENTAL HISTORY

General Dentist _____ Date of last visit _____
Did your dentist refer you to our office? YES or NO (circle response)
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience “tension” headaches? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
What is the patient’s attitude toward receiving orthodontic treatment? _____
Height of parents? Mom _____ Dad _____

## BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Barakat perform a complete orthodontic evaluation.

Signature: _____ Date: _____

# RELEASE AUTHORIZING USE OF PERSONAL PHOTOGRAPHS

I, _____ consent to the use of my/my child's _____ personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by Dr, Barajat and her staff ("Opus 1") for any lawful use Opus 1 deems appropriate, including for treatment, advertising its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational purposes.

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by Opus 1 during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Opus 1. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Opus 1 will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that Opus 1 cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Opus 1 may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Opus 1 may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness.

I have read the foregoing in its entirety and understand its terms.

_____ _____

Patient name Guardian Name/Relationship to Patient

_____ _____

Patient/guardian signature Date

_____ _____

Dr. Barakat Date