Koglin Orthodontics

James W. Koglin, D.D.S.

CHILD'S NAME:_____NICKNAME:_____

BIRTHDATE:_____ AGE_____ SEX _____M_____F_____

HOME ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL:_____

MOTHER/STEPMOTHER/OTHER:_____

E-MAIL:_____CELL:_____

FATHER/STEPFATHER/OTHER_____

E-MAIL:_____CELL:_____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

DENTAL INSURANCE:

INSURED'S NAME:_____DATE OF BIRTH:_____

EMPLOYER:_____

INSURANCE COMPANY:_____PHONE:_____

INSURED'S ID NUMBER OR SS#_____GROUP NO:_____

INS. CO. ADDRESS:_____

ADDITIONAL DENTAL INSURANCE:

INSURED'S NAME:_____DATE OF BIRTH:_____

EMPLOYER:_____

INSURANCE COMPANY:_____PHONE:_____

INSURED'S ID NUMBER OR SS#_____GROUP NO:_____

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WHO MAY WE THANK FOR REFERRING YOU TO THE OFFICE:_____

CHILD'S INTEREST/HOBBIES/SPORTS:_____

PLEASE COMPLETE OTHER SIDE

## MEDICAL HISTORY:

Has your child had any difficulty with previous dental visits?_____Impressions/Molds_____

Is Minor/Child taking any prescription/over the counter drugs?_____YES_____No

Ever been hospitalized? Yes or NO Ever had surgery? Yes or No

Has your child ever had any of the following diseases or medical problems? (Please circle option that applies)

| | | | | | |
|---|---|---|---|---|---|
| ASTHMA | YES NO | ALLERGIES | YES NO | CANCER | YES NO |
| HEPATITIS | YES NO | DIABETES | YES NO | THYROID DISEASE | YES NO |
| HIV/AIDS | YES NO | HEMOPHILIA | YES NO | RHEUMATIC FEVER | YES NO |
| HEART MURMUR | YES NO | TUBERCULOSIS | YES NO | ABNORMAL BLEEDING | YES NO |
| SINUS PROBLEM | YES NO | DRUG/ALCOHOL ABUSE | YES NO | CONGENITIAL HEART DEFECT | YES NO |
| | | HANDICAPS/DISABILITIES | YES NO | | |

Please explain any other medical problems: (including Allergies) that your child has:_____

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## CHILD'S HABITS:

How often does your child brush?_____Floss:_____

Dentist:_____Last dental visit?_____

Child's Physician:_____Phone:_____

Is your child's water fluoridated? __ Yes __No Does your child take fluoride supplements?__ Yes ___ No

Does your child: Suck thumb/fingers Yes No Suck/bite lips Yes No Bite/Chew Nails Yes No

Chew hard objects? Yes No Grind Teeth Yes No Clench Jaw Yes No

Please list anything else we should know about your child's health:_____ _____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I understand 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. I authorize the dental staff to perform any necessary dental services for my minor/child.

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SIGNATURE DATE

# Koglin Orthodontics

## PRIVACY NOTICE ACKNOWLEDGMENT

I hereby acknowledge that have received a copy of Notice of Privacy Practices for Koglin Orthodontics.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Signature | Date |

☐ Check her is patient is a minor and sign below

☐ Check here if you are the patient's legal Representative (other than a parent) sign below

and state relationship with the patient : _____

| _____ | _____ | _____ |
|---|---|---|
| Name of Parent or Legal Guardian | Signature | Date |

Cell Phone Use Policy:

1. I provide consent to Koglin Orthodontics to use my cell phone number to call or leave text messages regarding appointments.

2. I consent to Koglin Orthodontics to call using my cell phone regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My Cell phone number is (include area code) _____ Initial _____

THIS SECTION TO BE COMPLETED BY KOGLIN ORTHODONTICS PERSONNEL

Check Applicable situation below if acknowledgment was not obtained at the time of first delivery of service.

☐ In Emergency treatment situations, we will attemp to obtain acknowledgment of receipt of Privacy Notice as soon as practicable after the delivery of such treatment.

☐ Other (describle efforts to attempt to obtain acknowledgment and explain why acknowledgment was not obtained.

| _____ | _____ |
|---|---|
| Signature | Date |