CHILD PATIENT INFORMATION

Date: ________________

GETTING TO KNOW YOUR CHILD...

Patient Name: ________________ Nickname: ________________ Birthdate: ________________

Home Address: ________________ SSN: ________________ Sex: ❏ M ❏ F

City/State/Zip: ________________ School & Grade: ________________

Siblings Names & Ages: ________________

Home Phone: ________________ Cell Phone: ________________

Who does the child live with? Please list family members/relationship: ________________

____

Who has custody of this child? ________________

Who will be responsible for payment on this account? ________________

Name of the person filling out this form: ________________ Relationship to patient: ________________

WHAT ARE YOUR GOALS?

If you could change anything about your child's smile, what would it be? ________________

How long have you wanted this change? ________________

What factors have stood in your way? ________________

Does your child have concerns about undergoing orthodontic treatment? ________________

If anyone in your family has had braces with our office previously, or currently, please list their names ________________

____

How did you get referred to or learn about our office? Please check all that apply:

❏ My Dentist
❏ Word of Mouth
❏ Printed Advertisement
❏ Road Sign
Family Member ________________
Friend ________________
❏ Google search
❏ Digital Ad/Internet
❏ Reputation
❏ Commercial
❏ Website
Other: ________________

DENTAL INSURANCE INFORMATION

Policy Holder ________________ SSN: ________________ Birthdate: ________________

Employer: ________________ ID# ________________ Group# ________________

Insurance Company Name: ________________ Phone Number ________________

Insurance Company Address: ________________ City/State/Zip: ________________

Is the patient covered by 2 dental policies? If so, please complete the following for secondary:

Policy Holder ________________ SSN: ________________ Birthdate: ________________

Employer: ________________ ID# ________________ Group# ________________

Insurance Company Name: ________________ Phone Number ________________

Insurance Company Address: ________________ City/State/Zip: ________________

EMERGENCY INFORMATION

Name of nearest relative NOT living with you:______________________________

Relationship:______________________________

Complete Address: ______________________________ City/State/Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Please list any family members that we can disclose information to about the patient. This will include appointments, financial information, treatment information, insurance and anything involved with their care at this office:

Name:______________________________ Relationship to patient: ______________

Name:______________________________ Relationship to patient: ______________

Name:______________________________ Relationship to patient: ______________

MOTHER'S INFORMATION

Mother's Name: ______________ Email: ______________ Birthdate:__________

Home Address:______________________________ SSN: ______________

City/State/Zip: ______________________________ How long at this address? ______________

If less than 3 yrs, please list previous address:______________________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Employer:______________ Occupation: ______________ Time Employed:______

Spouse's Name (if other than dad): ______________ Spouse's Nickname:______________ Birthdate:__________

Spouse's Employer: ______________ Occupation: ______________ Time Employed:______

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

FATHER'S INFORMATION

Father's Name: ______________ Email: ______________ Birthdate: __________

Home Address:______________________________ SSN: ______________

City/State/Zip: ______________________________ How long at this address? ______________

If less than 3 yrs, please list previous address:______________________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Employer:______________ Occupation: ______________ Time Employed:______

Spouse's Name (if other than mom):______________ Spouse's Nickname:______________ Birthdate:__________

Spouse's Employer: ______________ Occupation: ______________ Time Employed:______

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

MEDICAL HISTORY

Is your child currently seeing a physician or taking medications? ❑ Y ❑ N

If yes, what is the diagnosis and what medication are they taking? ______________________________

____

Is your child allergic to any medications? If yes, please list with reaction ______________________________

____

Does your child have any known allergies to any type of metals? ❑ Y ❑ N

Does your child suffer from frequent headaches? ❑ Y ❑ N

Has your child had any significant injuries to their face or teeth? ❑ Y ❑ N

If yes, please explain: ______________________________

HAS YOUR CHILD HAD OR CURRENTLY HAVE ANY HISTORY OF THE FOLLOWING?

❑ AIDS/HIV	❑ Diabetes	❑ Hepatitis	❑ Rheumatic Fever
❑ Arthritis	❑ Ear Disorder	❑ Herpes/Oral Cold Sores	❑ Shoulder Pain
❑ Artificial Joint	❑ Fainting/Seizures	❑ High Blood Pressure	❑ Sleep Apnea
❑ Asthma	❑ Frequent Sinus Infections	❑ Joint Swelling	❑ Speech Problems
❑ Blood Disorder	❑ Glaucoma	❑ Liver Ailment	❑ Swollen Glands
❑ Bone Disorder	❑ Heart Murmur	❑ Neck Pain	❑ Tuberculosis
❑ Cancer	❑ Heart Trouble	❑ Psychiatric Treatment	❑ Ulcers

If yes to any of these, please describe: ______________________________

Are there any medical conditions not listed above? ❑ Y ❑ N

If yes, please describe: ______________________________

Physician/Pediatrician Name: ____________________ Phone: ____________ Last Exam Date: ____________

DENTAL HISTORY

Dentist Name: ____________________ Phone: ____________ Last Exam Date: ____________

Is there any dental treatment to be completed prior to orthodontic treatment? ______________________________

How often does your child brush their teeth each day? (Check) ❑ Several times ❑ Twice ❑ Once ❑ Less Than Once

How often does your child floss your teeth each day? (Check) ❑ Several times ❑ Twice ❑ Once ❑ Less Than Once

Has your child had or have any of the following habits? (Check all that apply)

❑ Lip Biting ❑ Nail Biting ❑ Thumb/Finger Sucking ❑ Gum Chewing ❑ Ice Chewing

Has your child ever experienced any of the following? (Check all that apply)

❑ Ear Aches ❑ Jaw clicking/popping ❑ Jaw Joint Pain ❑ Jaw Locking ❑ Facial Pain

❑ Face Tightness/Sore ❑ Clenching ❑ Grinding ❑ Painful Chewing

Have you consulted with an orthodontist previously? ❑ Y ❑ N Whom/When? ____________________

If yes, what was it that caused you to seek another opinion? ______________________________

I certify that the above information is true, and to the best of my knowledge.

Parent Signature ______________________________ Date: ____________

John F. Monacell, D.D.S., P.C.

Specialist in Adult & Child Orthodontics and Dentofacial Orthopedics

1343 East Williamsburg Road • Sandston VA 23150-9448 • Chamberlayne Road, Suite B • Mechanicsville VA 23116

(804) 737-6757 www.monacellorthodontics.com (804) 746-0918

PEDIATRIC SLEEP QUESTIONNAIRE

Dr. Monacell would like you to complete the following questionnaire for your child to help him evaluate their current sleep and airway situation which plays a major role in dental development.

Please check if…

- ❑ While sleeping, does your child snore more than half the time?
- ❑ While sleeping, does your child always snore?
- ❑ While sleeping, does your child snore loudly?
- ❑ While sleeping, does your child have “heavy” or loud breathing?
- ❑ While sleeping, does your child have trouble breathing, or struggle to breath?
- ❑ Have you ever seen your child stop breathing during sleep?
- ❑ Does your child tend to breathe through their mouth during the day?
- ❑ Does your child have a dry mouth when waking in the morning?
- ❑ Does your child occasionally wet the bed?
- ❑ Does your child awake un-refreshed in the morning?
- ❑ Does your child experience sleepiness during the day?
- ❑ Has a teacher or supervisor commented that your child appears sleepy or sluggish during the day?
- ❑ It is hard to waken your child in the morning?
- ❑ Does your child ever wake up with headaches?
- ❑ Did your child ever stop growing at a normal rate?
- ❑ Is your child overweight?
- ❑ Your child does not seem to listen when spoken to directly.
- ❑ Your child is often easily distracted.
- ❑ Your child often has difficulty organizing tasks and activities. Your child fidgets or squirms.
- ❑ Your child is often “on the go” or acts as if “motor driven”.
- ❑ Your child often interrupts or intrudes.
- ❑ Does your child suck their thumb?
- ❑ Does your child have acid reflux?
- ❑ Does your child grind their teeth excessively?

Child Name: ____

Parent Signature ______________________________________ Date: ______________

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NOTICE OF PRIVACY PRACTICES (HIPAA)

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e. your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e. to determine the results of cleanings, surgery, etc.)
- To third party payers or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, dates of payment, etc.)
- To certifying, licensing and accrediting bodies (i.e. American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation.
- Internally, to all staff members who have any role in your treatment.
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment.
- To contact you in order to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- To email your x-rays, photos, and treatment plan to your other doctors as needed.
- To leave messages or email you regarding upcoming appointments.

Your Rights Regarding Your Health Information

You may ask us to communicate with you in a confidential manner, ask to see or obtain photocopies of your health information and/or ask us to amend your health information if you feel that it is inaccurate or incomplete.

Acknowledgments and Permissions

Please check all that you are acknowledging and granting permission!

❏ I give permission for my child's photo to be displayed in this office.

❏ I give permission for my child's photos, x-rays, study models and other diagnostic, treatment and demographic information to be used for the following purposes: Research, Lectures/Presentations, Publications and Practice Marketing.

❏ I give permission for the office of Dr. John Monacell to contact me on my cell phone, email, or any other phone number that I have listed, regarding my account, appointments, insurance, treatment, etc.

❏ I hereby acknowledge that I have received, read and reviewed a copy of this notice of Privacy Practices, the consent to treatment and office procedures. I authorize use of my signature on and release of information for insurance submissions.

Signature of Responsible Party ______________________________ Date: ____________

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