About Your Child
Please circle or check the appropriate areas.

Today's Date: _____
[ ] Male
[ ] Female
Child's Name:

_____
LAST *FIRST* *MI*
Nickname: _____
SS#: _____-_____-_____
Child's Birth Date: _____/_____/_____
Child's Age: _____
School: _____
Grade: _____
Hobbies/Sports: _____
_____
Child's Primary#: _____
Home/Cell/Business
Child's Home Address:

_____
APT#
_____
CITY *STATE* *ZIP*

General Dentist: _____
Address: _____
_____
CITY *STATE* *ZIP*
Phone#: _____
Last Visit Date: _____

List brothers/sisters and ages: _____
_____
_____

Whom may we thank for referring you? _____
_____

[ ] Mother's Information [ ] Step Mother [ ] Guardian

Name: _____
Birth Date: _____/_____/_____
Primary Phone#: _____
Home/Cell/Business
Secondary Phone#: _____
Home/Cell/Business
Employer: _____
*SS#:*_____-_____-_____
Email: _____

[ ] Father's Information [ ] Step Father [ ] Guardian

Name: _____
Birth Date: _____/_____/_____
Primary Phone#: _____
Home/Cell/Business
Secondary Phone#: _____
Home/Cell/Business
Employer: _____
SS#: _____-_____-_____
Email: _____

Parents' Marital Statues:

[ ] Single
[ ] Married
[ ] Widowed
[ ] Divorced
[ ] Separated

Who is accompanying your child today? _____
Relationship to child? _____
Do you have legal custody of this child? _____

Person(s) Responsible for Account

Name: _____ _____%
Relationship: _____
Address: _____
_____
CITY *STATE* *ZIP*
Primary Phone#: _____
Home/Cell/Business

Name: _____ _____%
Relationship: _____
Address: _____
_____
CITY *STATE* *ZIP*
Primary Phone#: _____
Home/Cell/Business

Primary Orthodontic Insurance

Orthodontic coverage? [ ] Yes [ ] No
Insurance Company Name: _____
Insurance Company Address: _____
_____
CITY *STATE* *ZIP*
Insurance Company Phone #: _____
Policy Holder/Subscriber ID (SSN or ID#):
_____
Plan/Group Number: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birth Date: _____/_____/_____
Policy Owner's SS#: _____-_____-_____
Policy Owner's Employer: _____

Secondary Orthodontic Insurance

Orthodontic coverage? [ ] Yes [ ] No
Insurance Company Name: _____
Insurance Company Address: _____
_____
CITY *STATE* *ZIP*
Insurance Company Phone #: _____
Policy Holder/Subscriber ID (SSN or ID#):
_____
Plan/Group Number: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birth Date: _____/_____/_____
Policy Owner's SS#: _____-_____-_____
Policy Owner's Employer: _____

What are the main concerns that you would like Orthodontics to address?

_____
_____
_____
_____

Has your child ever been evaluated for or had orthodontic treatment before? [ ] Yes [ ] No

Have there been any injuries to the face, mouth, teeth, or chin? [ ] Yes [ ] No

List any musical instruments played: _____
_____

Have adenoids or tonsils been removed? [ ] Yes [ ] No

Has your child been informed of any missing or extra teeth? [ ] Yes [ ] No

Has your child ever had any pain/tenderness in his/her Jaw joint (TMJ/TMD)? [ ] Yes [ ] No

Does your child brush his/her teeth daily? [ ] Yes [ ] No
Floss his/her teeth daily? [ ] Yes [ ] No

Child's Physician: _____
Phone#: _____
Date of last Visit: _____

Is your child currently under the care of a physician? [ ] Yes [ ] No

Has puberty begun? [ ] Yes [ ] No

Has menstruation begun? (Girls) [ ] Yes [ ] No [ ] N/A

Please describe your child's current physical health: [ ] Good [ ] Fair [ ] Poor

Please list all drugs your child is currently taking:

_____
_____
_____

Please list all drugs your child is allergic to:

_____
_____
_____

Does/Did your child have any of the following habits?

[Y] [N] Clenching/Grinding
[Y] [N] Lip Sucking/Biting
[Y] [N] Mouth Breather
[Y] [N] Nail Biting
[Y] [N] Nursing Bottle Habits
[Y] [N] Speech Problems
[Y] [N] Thumb/Finger Sucking
[Y] [N] Tongue Thrust

Has your child ever had any of the following medical problems?

[Y] [N] Abnormal Bleeding
[Y] [N] Allergy to any Drugs
[Y] [N] Allergy to Latex/Metals
[Y] [N] Allergy to Plastic
[Y] [N] Any Hospital Stays
[Y] [N] Any Operations
[Y] [N] Asthma
[Y] [N] Cancer
[Y] [N] Congenital Heart Defect
[Y] [N] Convulsions/Epilepsy
[Y] [N] ADD/ADHD
[Y] [N] Diabetes
[Y] [N] Handicaps/Disabilities
[Y] [N] Hearing Impaired
[Y] [N] Heart Murmur
[Y] [N] Hemophilia
[Y] [N] Hepatitis
[Y] [N] HIV+/AIDS
[Y] [N] Kidney/Liver Problems
[Y] [N] Rheumatic/Scarlet Fever
[Y] [N] Tuberculosis (TB)

Please Discuss any medical problems that your child has had: _____
_____
_____
_____
_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidences 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 services my child may need.

The parent or Guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

_____
Signature

_____
Date

Voice Message Communication

☐ *I authorize your office to leave voice messages for me on my home phone revealing the identity of your office. I also authorize you to leave voice messages concerning appointments, scheduling, and request for call back without mentioning specifics. I will accept responsibility for the privacy issues that may arise.*

☐ *I do not authorize you to leave any voice messages for me from the office.*

Signature: _____

Date: _____

Agreement to Receive Electronic Communication

Marble Hill Orthodontics, P.C. – Dr. Bruce J. Jiorle, D.M.D.

_____

Patient Name: _____

Date of Birth: _____

I agree that the Marble Hill Orthodontics, P.C. – Dr. Bruce J. Jiorle, D.M.D. may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:
(908) 859-4555

Email Address (PLEASE PRINT CLEARLY):

_____

Signature: _____

Date: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Marble Hill Orthodontics, P.A. to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature of Parent or Guardian *Date*

_____ _____

Signature *Date*

Acknowledgement of Receipt of Notice of Privacy Practices

Marble Hill Orthodontics, P.A. – Dr. Bruce J. Jiorle, D.M.D.

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ *Individual refused to sign*
- ☐ *Communications barriers prohibited obtaining the acknowledgement*
- ☐ *An emergency situation prevented us from obtaining acknowledgement*
- ☐ *Other (Please Specify)*

_____

_____

_____