Welcome to the Orthodontist

Kowalczyk Orthodontics
2752 Forgue Dr., Suite 106
Naperville, IL 60564

Patient's Name_____**Age**_____**Birth Date**_____**Sex**_____

Address_____
Street City Zip Code

Patient Social Security Number (*Required*)_____

Person(s) responsible for financial matters:

Name_____

Address_____
Street City Zip Code

Appointment Reminder Information (*necessary to send appointment reminders):

***Cell Phone**_____ ***Cell Phone Provider**_____

***Home Phone**_____

***Email**_____

Primary Orthodontic Insurances:	**Secondary Orthodontic Insurance:**
Insurance Co. Name_____	_____
Insurance Co. State_____	_____
Insurance Co. Phone #_____	_____
Member ID _____	_____
Group #_____	_____
Policy Owner's Name_____	_____
Insurer Birth Date_____	_____
Insurer SSN (*Required*)_____	_____

Family Dentist	**Whom can we thank for referring you?**
Business Name_____	_____

Dentist_____

Phone_____

Family History:

Marital Status of Patient or Parent (if minor) _____

Family History if Patient is a Minor:

Father's Name_____**Living?** **No**☐ **Yes**☐ **Occupation**_____

Mother's Name_____**Living?** **No**☐ **Yes**☐ **Occupation**_____

Siblings (name and age)

Patient Living with: **Mother**☐ **Father**☐ **Spouse**☐ **Self**☐ **Other**☐

Medical and Dental History

Has the patient ever had: (Please place an X)

☐ **AIDS**	☐ **Diabetes**	☐ **Head or Face Injury**	☐ **Rheumatic Fever**
☐ **Anemia**	☐ **Endocrine Problems**	☐ **Hepatitis**	☐ **Thyroid Problems**
☐ **Arthritis**	☐ **Emotional Problems**	☐ **Herpes**	☐ ***Previous Surgery**
☐ **Asthma**	☐ **Epilepsy/Seizures**	☐ **Kidney Disease**	☐ ***Allergy**
☐ **Bleeding**	☐ **Hearing Problems**	☐ **Lung Disease**	☐ ***Other**
☐ **Cold sores**	☐ **Heart Condition**	☐ **Oral Ulcer**	

Comments (*Describe If Starred)_____

Is the patient under the care of a physician (other than routine care) ☐ **No** ☐ **Yes: Condition**_____

Is the Patient requiring premedication for dental procedure? **No**☐ **Yes**☐

Present medications_____

Does the Patient:

Breathe through the mouth?	**No**☐	**Yes**☐
Snore?	**No**☐	**Yes**☐
Have frequent colds?	**No**☐	**Yes**☐
Have frequent sore throats or tonsillitis?	**No**☐	**Yes**☐
Have difficulty chewing or swallowing?	**No**☐	**Yes**☐

Any unusual dental experiences? Please explain_____

Does the Patient:

Have difficulty in mouth opening?	**No**☐	**Yes**☐
Have pain, popping, or clicking in the jaw joints(s)?	**No**☐	**Yes**☐
Have pain with chewing, yawning, or wide opening?	**No**☐	**Yes**☐
Have pain in or around the ears or cheeks?	**No**☐	**Yes**☐
Have an uncomfortable bite?	**No**☐	**Yes**☐
Have a jaw that locks?	**No**☐	**Yes**☐

Habits

Thumb/finger/lip sucking until _____ (age)
Clenching or grinding of teeth **No**☐ **Yes**☐
Tongue Thrusting or other functional problem **No**☐ **Yes**☐

Orthodontic History

Has the patient had previous orthodontic consultation(s) **No**☐ **Yes**☐ **or treatment? No** ☐ **Yes**☐

Date:_____ **Dr.**_____

Signature of individual completing this form:_____

Today's date:_____

Margaret B. Kowalczyk D.D.S., M.S., P.C

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent:

Patient Name:_____

Address:_____

Section B: To the Patient – Please Read the Following Statement Carefully:

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, and healthcare operations**.**

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health 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 Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You many obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office:

Telephone: 630-355-1780 **Fax**: 603 355-7303
Address: 2752 Forgue Dr. Suite 106
Naperville, IL 60564

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 your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent for and Your Notice Of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your uses and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ **Date:**_____

If the patient is under 18, and this form is being filled out on their behalf by a personal representative, please complete the following:

Personal Representative's Name:_____

Relationship to Patient :_____