ORTHODONTIC ACQUAINTANCE CARD

PATIENT'S NAME _____ AKA _____ DOB _____ AGE _____ SEX _____
Last First

ADDRESS _____ CITY _____ ZIP _____ TELEPHONE _____

REFERRED BY _____ SCHOOL _____ HOBBIES _____

PATIENT'S DENTIST _____ LAST DENTAL CLEANING _____ PHYSICIAN _____

FATHER'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ CELL# _____ EMAIL _____

MOTHER'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ CELL# _____ EMAIL _____

PERSON RESPONSIBLE FOR ACCOUNT _____ PHONE# _____

ADDRESS IF DIFFERENT THAN ABOVE _____ PARENTS ARE: MARRIED ☐ SINGLE ☐ DIVORCED ☐

RESPONSIBLE PARTIES DRIVERS LICENSE# _____ RESPONSIBLE PARTY E-MAIL ADDRESS _____

FATHER'S SS# _____ CHILD LIVES WITH _____

MOTHER'S SS# _____ DENTAL INSURANCE _____

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? _____ YES ☐ NO ☐

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____ YES ☐ NO ☐

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ILLNESS? _____ YES ☐ NO ☐

PLEASE LIST _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

DIABETES ☐	TUBERCULOSIS ☐	ENDOCRINE PROBLEMS ☐
FEVER BLISTERS ☐	CONTACT LENSES ☐	PROLONGED BLEEDING ☐
HEART TROUBLE ☐	EPILEPSY ☐	FAINTING OR DIZZINESS ☐
RHEUMATIC FEVER ☐	ASTHMA ☐	NERVOUS DISORDERS ☐
BONE DISORDERS ☐	KIDNEY INVOLVEMENT ☐	LIVER INVOLVEMENT ☐
HEPATITIS ☐	GLAUCOMA ☐	CEREBRAL PALSY ☐

GROWTH RATE SLOW ☐ AVERAGE ☐ FAST ☐

RESEMBLES MOTHER ☐ FATHER ☐ ADOPTED ☐

DISPOSITION OBEDIENT ☐ COOPERATIVE ☐ INDEPENDENT ☐ REBELLIOUS ☐

DOES PATIENT HAVE TENDENCY TO COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES ☐ NO ☐ WHAT AGE? _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

HAS THE PATIENT REACHED PUBERTY? GIRLS-HAS SHE STARTED MENSTRUATING? _____ YES ☐ NO ☐

BOYS-HAS HIS VOICE CHANGED? _____ YES ☐ NO ☐

DENTAL HISTORY

HAS PATIENT HAD PRIOR ORTHODONTIC TREATMENT? _____ YES ☐ NO ☐

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ YES ☐ NO ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ YES ☐ NO ☐

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ YES ☐ NO ☐

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE YES ☐ NO ☐ WHILE ASLEEP YES ☐ NO ☐

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ YES ☐ NO ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ YES ☐ NO ☐

LIST ANY MUSICAL INSTRUMENTS PLAYED _____

REASON FOR CONSULTATION _____

FORM COMPLETED BY X _____ DATE _____
PARENTS SIGNATURE

SIBLINGS INFORMATION

As you know it is very important to begin orthodontic treatment at the correct time. It would be very helpful to have some additional information about the members of your immediate family. This would give us a good idea as to when they might benefit from a FREE orthodontic evaluation.

Thank You.

Dr. Copenhaver, Dr. Lugo, Dr. Schechter & Dr. Nurko

Patient Name · _____

Please list brothers and sisters from youngest to the oldest.

First Name	Last Name	Birth Date	School Grade	Sex
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

Thanks again.

NORTH TEXAS ORTHODONTIC ASSOCIATES, P.A.
NTOA
Our Braces Make Smiling Faces

Members American Association of Orthodontists

Donald J. Copenhaver, D.D.S. • Robert J. Lugo, D.M.D.
Carlos Nurko, D.D.S. • Jerome S. Schechter, D.D.S.
www.ntoabraces.com

HIPPA Consent Form

Patient Name:_____

HIPPA-Notice of Privacy Practices

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how North Texas Orthodontic Associates, P.A. may use or disclose your health care information. The Notice explains the rights that you are guaranteed under HIPPA regulations. North Texas Orthodontic Associates, P.A. has always taken great care to protect the integrity and confidentiality of your health care information, we are required by the HIPPA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice. Our Notice of Privacy Practices is available for you to view on our website, www.ntoabraces.com, or a copy can be obtained by contacting our office.

I certify that I have had the opportunity to review the Notice of Privacy Practices of North Texas Orthodontic Associates, P.A.

Name of Responsible Party_____

Responsible Party E-mail_____

Relationship to Patient_____

Signature_____

Date_____

Financial Responsibility Acknowledgement

Patients Name_____

After your complimentary exam, if you are ready to begin treatment, you will be instructed to go to Collin County Imaging for your orthodontic records and a 3-D scan. These are needed for the doctor to complete his diagnosis and treatment planning of your case. There will be a charge applied to your account at the time the orthodontic records are received at North Texas Orthodontics Associates. If your orthodontic treatment is scheduled to start within 30 days from the date the x-rays were taken, this charge is included in your total orthodontic case fee.

Collin County Imaging will file your medical insurance for the 3-D scan. NTOA has made arrangements with Collin County Imaging stating they will accept what the medical insurance pays and there will be no out of pocket expense for the scan and evaluation. All charges outside what insurance pays are included in the orthodontic case fee.

I understand that there is no charge for the initial exam. When I pursue orthodontic treatment with North Texas Orthodontic Associates and have my orthodontic records taken by Collin County Imaging, I understand that I will be responsible for charges incurred.

I understand that Collin County Imaging will file my medical insurance for the 3-D scan and evaluation.

_____ _____

Responsible Party Signature Date

_____

Print Responsible Party Name

Authorization to release information/ Assignment of Insurance Benefits:
I authorize the release of information to my treatment and hereby authorize payment directly to the dental group/imaging group if the insurance benefits otherwise payable to me.

_____

Responsible Party Signature