Aloha ORTHODONTICS
Pamela Regimbal, D.D.S., PLLC

8266 Jupiter Drive
Mechanicsville, VA 23116
Phone: 804.746.7720
Fax: 804.200.4349

www.alohabraces.us

Patient Information — Child

All About Your Child

Name:_____
Last First MI
Nickname:_____
Male/ Female Birthdate:____/____/_____ Age:_____
School:_____Grade:_____
Hobbies/Sports:_____
Child's Home: # ( ) _____
Child's Home Address:_____
City:_____State:_____Zip:_____

Who is Accompanying Your Child Today?

Name:_____ Relation:_____
Do you have legal custody of this child? Y N
Whom may we thank for referring you?_____
Other family members seen by us?_____
_____

Dentist

General Dentist:_____
Date of Last Exam:_____

Mother Stepmother Guardian

Name:_____
Last First
Birthdate:_____/_____/_____
Employer:_____
Work: # ( )_____ Cell: # ( )_____
Email:_____

Father Stepfather Guardian

Name:_____
Last First
Birthdate:_____/_____/_____
Employer:_____
Work: # ( )_____ Cell: # ( )_____
Email:_____

Who will be responsible for making appointments?:
_____
Who will be responsible for the account?
_____
What are your main concerns that you would like orthodontics to accomplish?
_____

Has your child ever had or been evaluated for orthodontic treatment? Y N
Have there ever been any injuries to the face, mouth, teeth or chin? Y N
Does your child brush his/her teeth daily? Y N
Floss his/her teeth daily? Y N
Has puberty begun? Y N
Has menstruation begun? (Girls) Y N
Does your child now have or ever experienced pain or discomfort in their jaw joint (TMJ/TMD)? Y N

Child's Physician:_____
Phone: # ( )_____
Is your child currently under the care of a physician? Y N
Please list all drugs your child is currently taking: _____
_____
Please all drugs/things your child is allergic to: _____
_____

Please indicate whether your child has ever had any of the following medical problems:

Abnormal Bleeding	Y	N	Allergies to any drugs	Y	N
Allergic to Latex/Metals	Y	N	Allergic to plastic	Y	N
Asthma	Y	N	Cancer	Y	N
Congenital Heart Defects	Y	N	Convulsions/Epilepsy	Y	N
Diabetes	Y	N	Handicaps/Disabilities	Y	N
Hearing Impairment	Y	N	Heart Murmur	Y	N
Hemophilia	Y	N	Hepatitis	Y	N
HIV+/AIDS	Y	N	Hospitalization	Y	N
Kidney/Liver Problems	Y	N	Operations	Y	N
Rheumatic/Scarlet Fever	Y	N	Tuberculosis	Y	N

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

Has your child ever had any of the following habits?

Clenching/Grinding	Y	N	Lip Sucking/Biting	Y	N
Nail Biting	Y	N	Tongue Thrusting	Y	N
Mouth Breathing	Y	N	Thumb/Finger Sucking	Y	N
Soda Pop Drinker	Y	N			

I understand that the information I have provided is correct to the best of my knowledge and that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature of Parent/Guardian Date

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Account & Insurance Information

PATIENT NAME: _____ DATE: _____

BIRTHDATE: _____

RESPONSIBLE PARTY

Name: _____

Relation: _____ SS#: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home #: ( )_____ Email: _____

Employer: _____ Work #: ( ) _____

PRIMARY DENTAL INSURANCE

Policy Holder: _____

Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: ( )_____ Cell #: ( ) _____

SS#: _____ Birthdate: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: ( )_____ Ext: _____

Insurance Company: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Group #: _____

Plan #: _____

Subscriber ID #: _____

Phone #: _____

SECONDARY DENTAL INSURANCE

Policy Holder: _____

Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: ( )_____ Cell #: ( )_____

SS#: _____ Birthdate: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: ( )_____ Ext. _____

Insurance Company: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Group #: _____

Plan #: _____

Subscriber ID #: _____

Phone #: _____

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Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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Permission To Discuss Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

OR

_____ Initial here if you do not wish to release you/or your child's protected information to anyone.

This authorization permits Aloha Orthodontics to use and/or disclose the following individually identifiable health information about myself/or my child. It is understood that Aloha Orthodontics will only disclose information relevant to current treatment.

Signature: _____ Date: _____

Relationship to Patient: _____

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What's Most Important to You?

We consider your satisfaction to be of the utmost importance, and this starts by personalizing your orthodontic experience. Please review the treatment aspects below that our skilled team of professionals can deliver using several state-of-the-art technologies.

(Please rank your top three treatment aspects from 1 to 3)

_____ **Aesthetics**: I would prefer it if people don't notice that I'm in orthodontic treatment.

_____ **Colors**: I want to have fun displaying different colors (on holidays, for sports teams, etc.).

_____ **Comfort**: I want the highest degree of comfort possible during treatment.

_____ **Length of time in Treatment**: I want to have a beautiful smile as quickly as possible.

_____ **Visit Frequency**: I want to come to the orthodontist as few times as possible.

_____ **Appointment Length**: I want to sit in the chair for short periods during adjustment appointments.

_____ **Schedule**: I'd like appointments to accommodate my own schedule (before or after school/work).

_____ **Punctuality**: I want to be seen on time for adjustment appointments.

_____ **Treatment Cost**: The down payment and monthly payment are major considerations.

_____ **Other**: _____