L. Ruth Berry, D.M.D., P.A. ©

Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. Do let us know if you have any questions. We'll be glad to help you. We look forward to working with your child!

PATIENT INFORMATION

Child's Name _____
Last First MI

Nickname _____ Age _____ Date of Birth _____ ☐ Male ☐ Female

Child's Home Address: _____
Street City State Zip

Home Phone number: (_____) _____ Email Address: _____

Child Resides with:

□ (Mother) Name: _____ Phone Number (_____) _____ cell / work
Phone Number (_____)_____ cell / work

□ (Father) Name: _____ Phone Number (_____)_____ cell / work
Phone Number (_____)_____ cell / work

□ (Other) Name: _____ Phone Number (_____)_____ cell / work

If "other," please specify your relationship: _____ Do you have legal custody of the child? □YES □NO

How would you prefer to be contacted? Please check at least two options: ☐ email ☐home phone ☐ cell phone ☐work phone

School _____ Whom may we thank for referring you? _____

Hobbies/Sports _____

Does your child play musical instruments? ☐ YES ☐ NO _____

Are there other family members seen by us? _____

BILLING INFORMATION

Name of person responsible for this account: _____ Phone #: _____

Billing Address (if different from child's): _____

Relation to child: _____ Soc. Sec.# _____ DL#: _____

Employer: _____ How long? _____ Email address: _____

INSURANCE INFORMATION

Do you have orthodontic insurance? □YES □NO Insurance Co.:_____

Insured Full Name:_____ Relation to patient: _____

ID# _____ Insured Soc. Sec.# _____ Insured D.O.B._____

Insurance Co. Phone #:_____ Employer _____ Group # _____

Please complete both sides

DENTAL HISTORY

General Dentist _____ Date of last visit: _____

What concerns you most about your child's teeth? _____

How often does your child brush his/her teeth? _____How often does he/she floss? _____

Do you child's gums bleed when brushing? _____

Has your child ever had an orthodontic evaluation before? _____

Has your child ever experienced a face, teeth, or chin injury? _____

Has your child have his/her tonsils or adenoids removed? _____

Has your child ever experienced an adverse reaction during a medical or dental procedure? _____

Does your child breathe through the mouth while awake? _____ Or asleep? _____

Does your child have any missing or extra permanent teeth? _____

Present habits affecting your child's mouth or teeth: ☐ thumb sucking ☐ nail biting ☐other: _____

Other concerns or pertinent information about your child's dental health or previous treatment that you would like to share with Dr. Berry: _____

_____

MEDICAL HISTORY

Name of physician _____ Phone number _____

Is your child under physician care? ☐YES ☐NO If yes, please describe: _____

Is your child allergic to any medications? ☐YES ☐NO If yes, please describe: _____

Is your child allergic to metals or latex? ☐YES ☐NO If yes, please describe: _____

Has your child ever had any serious illnesses or injuries? _____

Girls only -Has menstruation begun? ☐YES ☐NO Boys only -Has puberty begun? ☐YES ☐NO

Check (✓) yes or no if your child has had any of the following:

□Y □N AIDS/HIV Positive	□Y □N ADD / ADHD	□Y □N Hemophilia/abnormal bleeding	□Y □N Sinus problems
□Y □N Anemia	□Y □N Diabetes	□Y □N Herpes	□Y □N Skin rash
□Y □N Asthma	□Y □N Fainting	□Y □N Kidney disease	□Y □N Thyroid disease
□Y □N Blood disease	□Y □N Hepatitis	□Y □N Liver disease	□Y □N Tuberculosis
□Y □N Cancer/Chemotherapy	□Y □N Headaches	□Y □N Jaw pain or popping	□Y □N Handicap/Disability
□Y □N Convulsions/Epilepsy	□Y □N Heart problems	□Y □N Rheumatic/Scarlet fever	□Y □N Other _____
□Y □N Cough -persistent	□Y □N Hearing impairment	□Y □N Shortness of breath	

Other pertinent information about your child's health that you would like to share with Dr. Berry: _____

_____

Please list all medications your child is currently taking:

_____ for condition _____ Prescribing physician: _____

_____ for condition _____ Prescribing physician: _____

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

_____ _____

Signature Date

Patient Consent to Use and Disclosure Information for Treatment, Payment Health Care Operations

I, _____, parent or legal guardian for _____
Adult completing this form Patient name

understand that as part of my health care, Dr. L. Ruth Berry, D.M.D., P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the dental professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means which a third party can verify that services billed were actually provided
- A tool or routine operations, such as assessing quality reviewing the competence of staff

I have been provided with a Notice of Patient Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to view Notice prior to signing this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. treatment, payment

I further understand that Dr. L. Ruth Berry, D.M.D., P.A. reserves the right to change her notice and practices, in accordance with the Section 164.520 of the Code of Federal Regulations. Should Dr. L. Ruth Berry, D.M.D., P.A. change her notice, I may request a copy of any revised notice in person (or by U.S. mail, to be sent to the address I've provided).

I wish to have the following restrictions to the use of disclosure of my health information:
_____
_____

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operations:
Example: Spouse (name), children (names), other relatives (names) friend or caregivers (names), dentists (names), other doctors (names):
_____
_____

Appointment Reminders:
May we leave an appointment reminder message at your home using doctor's/practice name: Yes ( ) No ( )
May we leave an appointment reminder message at your work using doctor's/practice name: Yes ( ) No ( )

I understand that as part of treatment, payment, or healthcare operation, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and ACCEPT / DECLINE the terms of this consent.

_____ _____
Patient/Guardian Signature Print name of person signing

_____
Date
If other than patient is signing, are you the legal guardian, custodian or have Power of attorney for this patient, for treatment, payment or other healthcare operations: Yes ( ) No ( )

FOR OFFICE USE ONLY
( ) Consent received by _____ Date _____
( ) Consent refused by patient ( ) Restrictions
( ) Consent added to patient's record on

Dr. L. Ruth Berry D.M.D., P.A.

So that we may provide you with the best possible state of the art orthodontic services available, we feel it is necessary to take photographs. We would appreciate you taking the time to read and sign this consent form.

PHOTOGRAPHIC WAIVER AND CONSENT

I hereby give permission to Dr. L. Ruth Berry, or any staff she may designate, to take photographs for diagnostic purposes and to enhance the dental records. I agree that these photographs will remain the property of Dr. L. Ruth Berry. I further authorize Dr. Berry to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures, if in her judgment dental research, education or science will be benefited by their use. Patient photographs may also be used for illustration purposes when previewing types of esthetic dental treatment with other patients. ***It is specifically understood that in any such publications the patient will not be identified by name***.

_____

Patient Name

_____ _____

Patient Signature* Date

**** Patients under 18 years old:***

_____

Print name of Parent or Legal Guardian

_____ _____

Signature of Parent or Legal Guardian Date