# NEW PATIENT
# CHILD HEALTH HISTORY

SOUTHERN MINNESOTA ORTHODONTICS
DRS. WIEMERS, SWANSON & VAUBEL

Date: _____

Please assist us by completing the following questions:

**Patient's Name:** Sex: Age: Birthdate:

Address: City: Zip: Referred by:

School: Grade:

**Parent/Guardian 1:** DOB: Occupation: Cell #:

Social Security #: Employer: Work Phone:

**Parent/Guardian 2:** DOB: Occupation: Cell #:

Social Security #: Employer: Work Phone:

Parent's Marital Status: ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed

#Sisters #Brothers Family Rank

Patient lives with ☐Mother ☐Father ☐Other:

Person Responsible for Account: ☐Father ☐Mother ☐Other (Print Name):

Email Address for appointment reminders and receipts:

## ORTHODONTIC INSURANCE

Primary **Dental** Insurance Co: Group/Plan #: Orthodontic Coverage: ☐Yes ☐No

Insurance Co. Address: City: State: Zip:

Subscriber's Name: Subscriber's ID #: Subscriber's Birthdate:

Secondary **Dental** Insurance Co: Group/Plan #: Orthodontic Coverage: ☐Yes ☐No

Insurance Co. Address: City: State: Zip:

Subscriber's Name: Subscriber's ID #: Subscriber's Birthdate:

**I understand I am responsible for any balance not covered by insurance.**

**I authorize payment to be made directly to the orthodontist who has provided these services.** **Signature** _____ **Date** _____

## DENTAL HISTORY

1. Patient's Dentist: Date of Last Visit:
2. Have there been any injuries to the face, mouth or teeth? ☐YES ☐NO
3. Has the patient had or does he/she presently have any of the following habits? ☐Thumb or finger sucking ☐Lip biting ☐NO ☐Grinding of teeth at night ☐Mouth breathing
4. Has the patient been informed of any missing or extra permanent teeth? ☐YES ☐NO
5. Is the patient aware of sores, lumps or irritated areas in the mouth? ☐YES ☐NO
6. Has an orthodontist been consulted previously? ☐YES ☐NO
   Name: Date:
7. Has the patient ever been treated for: ☐Bite problem ☐TMJ ☐Periodontal disease
   If so, by whom? ☐NO
8. Does the patient have any speech problems? ☐YES ☐NO
9. Is the patient frightened or anxious about orthodontic treatment? ☐YES ☐NO
10. Is the patient concerned about the appearance of his/her teeth? ☐YES ☐NO
11. Is there anything the patient would like to change about his/her smile? ☐YES ☐NO
    If so, what:
12. Reason for consultation: _____
13. Has there ever been any orthodontic treatment for any other member of your family? ☐YES ☐NO
    Father (Dr. _____) Mother (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)
14. Are you satisfied with their results? ☐YES ☐NO _____

(over)

# MEDICAL HISTORY

1. What is the name of the patient's family physician? Date of last physical:

2. Has the patient reached puberty? ☐ YES ☐ NO
   Girls - started menstruating? Mo. ____ Yr. ____ ☐ YES ☐ NO
   Boys - voice changed? ☐ YES ☐ NO

3. Has the patient shown signs of increased growth recently? ☐ YES ☐ NO

4. Father's present height: _____ Mother's present height: _____
   Older brother's present height & age: _____ Older sister's present height & age: _____

5. What is the patient's approximate height?

6. Is the patient's general health good at this time? ☐ YES ☐ NO

7. Is the patient under the care of a physician at this time? ☐ YES ☐ NO
   Explain:

8. Is the patient taking any medication? ☐ YES ☐ NO
   Name:

9. Is the patient allergic to any medication? ☐ YES ☐ NO
   Name:

10. Has the patient had tonsils and adenoids removed? ☐ YES ☐ NO
    Age:

11. Has the patient ever had a serious illness or been hospitalized? ☐ YES ☐ NO
    Explain:

12. Does the patient have any special problems not listed? ☐ YES ☐ NO
    Explain:

13. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? ☐ YES ☐ NO
    If yes, antibiotic name and method:

## DOES THE PATIENT HAVE NOW OR HAS HE/SHE EVER HAD ANY OF THE FOLLOWING:

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Endocarditis | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Heart Condition | ☐ | ☐ | AIDS or H.I.V. Positive | ☐ | ☐ | Psychiatric Treatment |
| ☐ | ☐ | Heart Pacemaker | ☐ | ☐ | Venereal Disease | ☐ | ☐ | Drug Addiction |
| ☐ | ☐ | Heart Attack (coronary) | ☐ | ☐ | Herpes (oral-cold sores) | ☐ | ☐ | Headaches |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Blood Disorder | ☐ | ☐ | Earaches |
| ☐ | ☐ | Congenital Heart Disease | ☐ | ☐ | Inflammatory Rheumatism | ☐ | ☐ | Jaw Clicking |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Arthritis | ☐ | ☐ | Allergies |
| ☐ | ☐ | Heart Surgery/Date _____ | ☐ | ☐ | Diabetes | ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Ulcers | ☐ | ☐ | Tonsillitis |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Stroke | ☐ | ☐ | Mental Health Concerns |
| ☐ | ☐ | Prosthetic (artificial) Joint | ☐ | ☐ | Anemia | ☐ | ☐ | Cancer |
| ☐ | ☐ | Radiation Therapy | ☐ | ☐ | Asthma | ☐ | ☐ | Other _____ |
| ☐ | ☐ | Respiratory Lung Disease | ☐ | ☐ | Epilepsy | | | |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Glaucoma | | | |
| ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Fainting Spells | | | |
| ☐ | ☐ | Hepatitis | ☐ | ☐ | Kidney Trouble | | | |

**If yes to any please explain:** _____

**I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising from inadequate information or information not disclosed. I UNDERSTAND THAT THE VISUAL EXAMINATION IS FREE OF CHARGE, HOWEVER THERE WILL BE A CHARGE FOR ANY DIAGNOSTIC RECORDS DEEMED NECESSARY.**

Signature of parent or guardian

Signature of Orthodontist

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

Update _____ Initial _____

**NOTES:**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

# SOUTHERN MINNESOTA ORTHODONTICS, P.A.
# CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE:_____

SECTION B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENTS 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 may obtain a copy of Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting.

Contact Person: Allison Schmidt
Telephone: 507-388-2989 Fax: 507-388-2985
Address: 1545 Adams Street, Mankato, MN 56001

**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 revoke this Consent.

**SIGNATURE:**

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

Signature:
_____Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:
_____

Relationship to Patient:
_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART.

# DO NOT SIGN BELOW

## Unless you are revoking your previously given consent for use and disclosure of health information.

**REVOCATION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

SOUTHERN MINNESOTA ORTHODONTICS

**CARLIN L. WIEMERS,** DDS, MS
*Diplomate, American Board of Orthodontics*
**TIMOTHY J. SWANSON,** DDS
*Diplomate, American Board of Orthodontics*
**CHRISTOPHER J. VAUBEL,** DDS, MS

# AAOIC SUPPLEMENTAL INFORMED CONSENT/QUESTIONNAIRE

## Communicable Diseases and Your Orthodontist

With community transmission of communicable disease, you could be exposed anywhere to infectious disease including, but not limited to Covid-19 (also called Coronavirus). Our orthodontic office is following the State of Minnesota and Federal regulations, recommend universal personal protection and disinfection protocols to limit transmission of communicable diseases. However, it is possible that these precautions will not always be successful in blocking the transmission of this disease. Social distancing nationwide has reduced the transmission of Covid-19, however, it is not possible to provide orthodontic treatment with social distancing between the patient, orthodontic staff and sometimes, other patients.

By presenting yourself or you child for orthodontic treatment, you assume and accept the risk that you or your child may inadvertently be exposed to a communicable disease.

If you have been exposed to a communicable disease prior to your orthodontic appointment, you may spread the disease to the orthodontist, orthodontic staff and to other patient/parents in the practice. Therefore, prior to each appointment, we require you to answer the following questions.

Have you, your child, or others accompanying you to today's appointment been tested positive for or been diagnosed as having Covid-19?

YES: _____ NO: _____

If so, when? DATE: _____

Do you or your child, or others accompany you to today's appointment have:

- A fever? YES: _____ NO: _____
- A cough? YES: _____ NO: _____
- Shortness of breath and/or trouble breathing?: YES: _____ NO: _____
- Persistent pain, pressure or tightness in the chest?: YES: _____ NO: _____

If any of you have any of these symptoms or have recently tested positive for or been diagnosed with Covid-19, you will be asked to reschedule your orthodontic appointment.

Do you acknowledge and accept the risk of exposure in our orthodontic office to a communicable disease, including but not limited to Covid-19, and consent to treatment?

Patient Name: _____ YES: _____ NO: _____

_____ DATE: _____

Patient/Parent's Signature