LOWE ORTHODONTICS
Spectacular Smiles, Exceptional Experience

Zachton J Lowe DDS MSD

Tell Us About Your Child

Today's Date: ____/____/____ Child's Home Phone #: (____)_____ Child's Birthday: ___/___/_____

Child's Name: _____ __Male __Female Child's Age:_____
LAST FIRST M.I.

Prefers to be called:_____ School:_____ Grade:_____

Who is accompanying your Child?_____ Relation:_____

Child's Home Address:_____
STREET CITY STATE ZIP

General Dentist:_____ My child was referred by:_____

Family Members in treatment in our office:_____

Hobbies/Sports/Musical instruments:_____

Parents Information

Parent's Marital Status: __Married __Divorced __Separated __Widowed __Remarried __Single __Partner

Name:_____ Relation:_____

Home Phone #: (____)_____ Cell #: (____)_____ Employer:_____Job Title:_____

Address (If different from child): _____
STREET CITY STATE ZIP

Name:_____ Relation:_____

Home Phone #: (____)_____ Cell #: (____)_____ Employer:_____ Job Title:_____

Address (If different from child): _____
STREET CITY STATE ZIP

Person(s) Responsible for Account:_____ Relation:_____

Address (If different): _____
STREET CITY STATE ZIP

Parent or Responsible Party E-Mail:_____

Dental Insurance Information

PRIMARY INSURANCE Orthodontic Coverage? __YES __NO (If no leave the rest blank)

Insurance Co:_____ Group # (Plan, Local, or Policy #): _____ ID #:_____

Subscriber's Name: _____ Relation to patient: _____

Subscriber's Birth Date: ___/___/_____ Social Security #:_____-____-_____ Subscriber's Employer:_____

SECONDARY INSURANCE Orthodontic Coverage? __YES __NO (If no leave the rest blank)

Insurance Co:_____ Group # (Plan, Local, or Policy #): _____ ID #:_____

Subscriber's Name: _____ Relation to patient: _____

Subscriber's Birth Date: ___/___/_____ Social Security #:_____-____-_____ Subscriber's Employer:_____

General / Dental Information

What major concerns do you have that you would like the doctor to address? _____

_____

Describe any previous orthodontic treatment or consultations._____

How does your child feel about orthodontic treatment?_____

Does your child have any pending dental work?_____

Have there been any injuries to the: __Face __Mouth __Teeth __Chin __None

Have Adenoids been removed? __YES __NO Tonsils? __YES __NO Date of Surgery(s)? ___/___/_____

Has your child been informed of any missing or extra permanent teeth? __YES __NO

Has your child ever had any treatment / pain / tenderness in his or her jaw joint (TMJ/TMD)? __YES __NO

Does your child take antibiotic pre-medication before any dental procedure? __YES __NO

Have you noticed any unusual changes in your child's face or jaws?_____

Does your child brush daily? __YES __NO Floss? __YES __NO

Does or did your child have any of the following habits or issues? (PLEASE CIRCLE THOSE THAT APPLY)

Lip Sucking OR Biting	Nail Biting	Chewing on Objects
Clench OR Grind Teeth	Suck Thumb OR Fingers	Tongue Thrust
Mouth Breather – Night OR Day	Speech Problems	Snores

Please give details of dental problems or habits circled:_____

_____

Medical History

Child's Physician: _____ Phone #: (____)_____ Date of last visit: ___/___/_____

Please describe the child's current physical health: __Good __Fair __Poor

Please list all medications / supplements that your child is taking:_____

Please list any Allergies your child has (Drugs, Environmental, Etc.):_____

Is your child pregnant or could be pregnant? __YES __NO Weeks #____

Does your child use any tobacco or have (had) a substance abuse problem? __YES __NO _____

Has your child experienced any of the following issues/problems? (PLEASE CIRCLE THOSE THAT APPLY)

Abnormal Bleeding/Bruising/Anemia	Arthritis or Joint Problems	Asthma or Sinus Problems
Birth/Hereditary Problems	Bone Fractures/Major Injuries	Cancer/Chemotherapy/Radiation
Diabetes or Hypoglycemia	Difficulty Breathing	Disabilities
Eating Disorders	Endocrine or Thyroid Problems	Epilepsy/Seizures/Fainting
Frequent Ear/Throat Infections	Heart Defect/Murmur	Hepatitis/Liver Problems
High/Low Blood Pressure	HIV/AIDS	Hospitalized for any reason
Immune System	Kidney Problems	Mental Health/Depression
Polio/TB/Mono/Pneumonia	Rheumatic Heart Disease	Severe/Frequent Headaches
Skin Disorder	Sleep Apnea	Tonsillitis
Ulcers/Hyperacidity/Reflux	Vision and Hearing Problems	Other_____

Please give details of medical problems circled or any others:_____

_____

_____

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature_____ Date_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature_____ Date_____

Privacy Consent

Authorization For Release of Patient Information

I acknowledge that I have been offered a copy of the Lowe Orthodontics Notice of Privacy Practices. I hereby authorize the above doctor(s) to provide other health care providers with information regarding this individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of the patient's protected health care information to the person(s) indicated below:

- ☐ No one
- ☐ Any immediate family member
- ☐ Other (Please Specify):_____

Patient Name_____

Parent/Guardian Signature_____ Date_____

Authorization and Consent To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Lowe Orthodontics to transmit patient information relating to my child's treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my child's treatment, payment for treatment, or Lowe Orthodontics health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My child's treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Lowe Orthodontics may use other ways to send my child's information, such as U.S. Mail, or may ask me to send my child's information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Lowe Orthodontics does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my child's patient information at any time, but if I do so, this will not affect emails that Lowe Orthodontics already sent before receiving my written instructions to stop.

Parent/Guardian Signature_____ Date_____