Orthodontics on Silver Lake, P.A.
Stephanie E. Steckel, D.D.S., M.S.
Welcome To Our Office

HEALTH HISTORY FOR CHILD

Date: ______/_______/______

Date of Birth:__________________________

Patient's name:____
First Middle Last

Age:__________ Grade:________ School: _____________________________________ Sex: ☐ Male ☐ Female

Preferred Telephone Number:____________________________ Other Phone:______________________________

Home Address:____ Zip Code:__________

Family Dentist: ____Last Check Up: ____________

How did you hear about our office: (check all that apply)

www.doverorthodontics.com Phone Book Dentist Hygienist Dentist Receptionist Internet

Patient/Relative/Friend: ______________________________ Other ________________________________

Patient lives with (*check all that apply, write name):*

Mother__________________ Father________________ Step-Mother_______________

Step-Father_______________ Other_________________

Birth Father's Name: ____________________________________ Spouse (if not birth mother):________________

Home Address if different from above: ____

Preferred Telephone #: __________________Occupation: _______________Employed By:___________________

Birth Mother's Name: ____________________________________ Spouse (if not birth father):________________

Home Address if different from above: ____

Preferred Telephone #: __________________Occupation: _______________Employed By:___________________

Names and Birth Dates of Other Children in Family:

____

____

Person responsible for financial account: ____

Do you have any insurance coverage for orthodontic treatment? ☐ Yes ☐ No

*Please provide your insurance information for us to help you submit of claims.

Primary Policy Holder's Name: ____

Dental Insurance Company: ____

ID /SS Number: Birthdate Group Number:

Medical History

Is the patient under the care of a physician for a specific problem at the present time? ☐ Yes ☐ No
If yes, explain: ____
List any medicines your child is currently taking: ____

Any drug sensitivities? Yes List: ________________________ No

Is there a history of serious illness, accident, or operation? ☐ Yes ☐ No If so, List: ________________________

____

If female, are you, or might you be PREGNANT? ☐ Yes ☐ No

PLEASE CHECK THE FOLLOWING AS THEY APPLY

Contact Lenses	High Blood Pressure	Asthma or Allergies	Speech Problems
Glaucoma	Head or Facial Injury	Rheumatic Fever	Emotional Problems
Heart Trouble	Tonsillitis	Diabetes	Endocrine Problems
Kidney Disease	Hearing Disorder	Bleeding Problems	Nervous Disorders
Ear Infection	Epilepsy	Adopted	Hepatitis/Liver Disease
Animal Allergies	AIDS, HIV+	Night Grinding of teeth	Tuberculosis
Latex Allergy	Nickel Allergy		

Has the patient reached puberty? Yes Month/Year ___________ No

Girls: Has she started menstruation? Yes No Boys: has his voice changed? Yes No

Please complete the following information as accurately as possible to help us evaluate family growth pattern.
Father: Height _____________ Mother: Height______________ Patient: Height ____________ Weight _________

Dental History

Have there been any injuries to the face, mouth, or teeth? ________________________	Yes	No	D/K
Have you ever had gum disease? ________________________	Yes	No	D/K
Do you get "Gum Boils", frequent canker sores or cold sores?______________________	Yes	No	D/K
Have you been informed of any missing or extra permanent teeth? __________________	Yes	No	D/K
Any serious trouble associated with any previous dental treatment? _________________	Yes	No	D/K
Has another orthodontist been consulted? If so by whom? _______________	Yes	No	D/K
Has anyone in your family had orthodontic treatment? ___________________________	Yes	No	D/K
Do you have an unusual amount of stress in your life?____________________________	Yes	No	D/K
Do you or have you ever smoked or chewed tobacco? ____________________________	Yes	No	D/K

Please list any family members treated here ____
Reason for seeking orthodontic treatment (what problem do you wish to have corrected?)

____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed above:______________________________
Patients Hobbies or Interest:

____

I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

____
Patient/Parent Signature

For Office Use Only:
☐ ID Verification

ORTHODONTICS
on Silver Lake, P.A.

WE WANT TO GET TO KNOW YOU!

Please tell us about yourself:

1. Nickname: ____

2. What are your hobbies and interests? ____________________________

____

3. Do you feel that your teeth are (circle all that apply):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Mishaped (uneven/pointed)	No	Yes
Off color?	No	Yes
Front teeth stick out(buck teeth)	No	Yes
Spaces between teeth	No	Yes

4. How do you feel about having braces or a retainer? ________________

____

5. Do you have friends or family that we treat/treated here? ______________

____

6. Do you have Facebook? ☐ Yes ☐ No

Become a fan of Orthodontics on Silver Lake!

WE ARE VERY EXCITED TO HAVE YOU AS A PATIENT AND A NEW FRIEND!

Dr. Stephanie Steckel ● 42 Hiawatha Lane ● Dover, DE 19904 ● 302-672-7776
www.doverorthodontics.com

Notice of Privacy Practice
Revised September 2013

Our Legal Duty: We are required by federal and state law to maintain privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We follow the privacy practices that are described in this Notice. This Notice takes effect (4/14/2003), and will remain in effect until we replace it. We reserve the right to change our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION
Treatment: We may use or disclose your health information to other healthcare providers providing treatment to you. This office is designed as an open bay treatment area. Discussion of our patient's treatment may occur at times in the open bay.

Payment: We may use and disclose your health information to obtain payment for services. This will include insurance information.

Your authorization for your family and friends: In addition to our use of your health information for treatment, payment or healthcare operations, we may disclose information to family members, chaperones, or friends that may be involved in your treatment. Please list their name and relationship below.

Required by law: If required by law, we may use or disclose your health information without your written authorization. We may disclose your information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or the health or safety of others.

Telephone/ Mail/ Email/Other Communications: With this consent, Orthodontics on Silver Lake, P.A. or our business associates may call your home, leave a message on your voicemail, mail correspondences to your home, and/or email any items that assist the practice in carrying out treatment, such as appointment reminders, financial statements, insurance items, and information pertaining to clinical care.

Marketing: I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations, office promotion and/or social media.

PATIENTS RIGHTS
Patients Right to Access: You generally have the right to look at and get copies of your health information. We will use the format you request unless we cannot practicable do so. We will charge you a reasonable cost-based fee for expenses such as copies and staffing time. Request for copies within 48 hours will be assessed with surcharge.

Questions and Complaints: We support your right to the privacy of your health information. You may file a complaint with us or with U.S. Department of Health and Human Services. If you want more information about our privacy practices or have questions please contact us.

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By signing this form, I am consenting to allow Orthodontics on Silver Lake, P.A. to use and disclose my health information to carry out treatment. Other uses of patient information will not be used without patients' written permission. Patients have the right to revoke an authorization as long as the patient does so in writing. This excludes situations in which the office has already relied on the authorization to use or disclose patient information and for purposes of obtaining insurance coverage.

____

(Print Patient's Name)

____

(Signature of Patient or Legal Guardian if under 18)

____

(Print Name of Legal Guardian if under 18)

____

(Date)

Who may we speak to about the patient's orthodontic treatment? List names and relationship below.

____

____

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