PATIENT NAME____________________ GENDER M or F BIRTHDATE__________

ADDRESS____________________ CITY____________ STATE____ ZIP__________

SCHOOL____________________ GRADE__________ NICKNAME____________

PATIENT LIVES WITH BOTH PARENTS MOTHER FATHER OTHER ____________________

FATHER'S NAME____________________ BIRTHDATE____________

ADDRESS, IF DIFFERENT____________________ CITY____________ STATE____ ZIP__________

CELL PHONE____________ HOME PHONE____________ WORK PHONE____________

EMPLOYER____________ SS#____/____/______ EMAIL____________________

MOTHER'S NAME____________________ BIRTHDATE____________

ADDRESS, IF DIFFERENT____________________ CITY____________ STATE____ ZIP__________

CELL PHONE____________ HOME PHONE____________ WORK PHONE____________

EMPLOYER____________ SS#____/____/______ EMAIL____________________

NUMBER OF BROTHERS ________ AGES ____________________

NUMBER OF SISTERS ________ AGES____________________

DENTIST____________ WAS THE PATIENT REFERRED BY THE DENTIST? ______ OTHER?____________

HAS THE PATIENT SEEN AN ORTHODONTIST BEFORE? ______ IF SO, WHEN?____________________

PLEASE COMPLETE OTHER SIDE

MEDICAL HISTORY

1. Your child's health has been.... GOOD AVERAGE POOR
2. Is your child under medical care now? _______ If so, for what? ________________________________
3. Is your child taking any medication? ________ Please list ________________________________
4. Is your child allergic to any medication? _______ Please list ________________________________
5. Please circle any of the following conditions your child has or has ever had:

Asthma	Diabetes	Hepatitis B	Severe Facial Injury
Anemia	Epilepsy	Hepatitis C	Tuberculosis
Blood Disease	Endocrine Problems	Latex Allergy	Vaso-Vagal Syncope
Bone Disorder	Emotional Problems	Polio	Food Allergy ______________
Convulsions	Heart Disease	Repeated Headaches	Nickel Allergy
CJD	Hearing Disorder	Rheumatic Fever	

Comments____

6. Please check all that apply:

___ allergies that affect breathing
___ snoring
___ breathe through the mouth when awake
___ breathe through the mouth when asleep
___ frequent sore throats or tonsillitis
___ chewing or swallowing difficulty
___ impacted teeth
___ tonsils and adenoids removed, when?_________
___ pain or clicking in the jaw
___ serious problems with cavities or gums
___ speech therapy
___ seen an allergist
___ seen an ENT specialist
___ any teeth removed by a dentist
___ jaw discrepancies
___ congenitally missing teeth

7. Please check any of the following habits your child has now or has had previously. Also indicate the age at which the habit was discontinued.

___Thumb sucking __________
___Finger sucking __________
___Lip biting or sucking __________
___ Pencil biting __________
___Grinding of teeth __________
___Tongue thrusting __________
___Nail biting __________
___Other __________

8. Does your child play a musical instrument? _____ If so, which one? __________________________
9. What sports or hobbies does your child participate? ______________________________________

By signing below I authorize the release of any information to my insurance provider to generate payment and for this practice to receive payment directly. I understand and agree that I am financially responsible for the balance on my account regardless of insurance status. If this account should become delinquent I understand that I will be held responsible for any and all cost, late charges, and additional fees that may be incurred in collection efforts.

SIGNATURE OF RESPONSIBLE PARTY____ DATE _________

DENTAL INSURANCE INFORMATION

PATIENT NAME ______________________________ BIRTHDATE_________________

PRIMARY DENTAL INSURANCE

POLICY HOLDER NAME___________________________________ RELATIONSHIP TO PATIENT_______________

ADDRESS ____ Phone#_______________

POLICY HOLDER BIRTHDATE _______________ SS# _________-______-_________

EMPLOYER____ ID#____________________________________

INSURANCE COMPANY _________________________________ INSURANCE CO. PHONE #______________________

INSURANCE CO. ADDRESS____

GROUP/POLICY#_______________

Office use only: max $____________ @______% Remaining________ age_______ effective_________

SECONDARY DENTAL INSURANCE

POLICY HOLDER NAME___________________________________ RELATIONSHIP TO PATIENT_______________

ADDRESS ____Phone#_____________

POLICY HOLDER BIRTHDATE _____________ SS# _________-______-_________

EMPLOYER____ ID#____________________________________

INSURANCE COMPANY _________________________________ INSURANCE CO. PHONE #__________________

INSURANCE CO. ADDRESS____

GROUP/POLICY#_______________

Office use only: max $____________ @______% Remaining________ age_______ effective___________

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO BURTON L. HAGLER DDS MS INC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

SIGNATURE OF PATIENT/GUARDIAN_______________________________________ **DATE**___________________

Privacy Policy

I. INTRODUCTION

Recently, the United States Department of Health and Human Services ("HHS") issued comprehensive regulations relating to the privacy of patient records. It is the intent of this office to comply with each of these new rules, and this policy is designed to provide a framework to accomplish this goal.

These rules apply to this office, however, we do not transmit patient records electronically. The rules apply to *all* "protected patient information," whether in electronic paper form, or whether disclosed orally. For purposes of this Privacy Policy, "protected patient information" includes any individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data. Employment records included within the definition (and thus not subject the privacy rule), unless they are used in connection with the provision of employment.

II. PRIVACY OFFICIAL

Diane Ashworth shall be this office's "privacy official." As such, she shall be responsible for implementing this Privacy Policy, as well as developing any future amendments or revisions to this Policy.

III. CONTACT PERSON

Diane Ashworth shall be this office's "contact person." She shall therefore be responsible for receiving any complaints or inquiries about patient privacy matters, and responding to such complaints or inquiries

The contact person shall document all complaints or inquiries received.

If any patient or other person desires to make a complaint relating to patient privacy, the Contact Person shall instruct him or her to submit the complaint in writing. The Contact Person Shall then investigate the complaint or inquiry, determine a resolution in conjunction with Dr. Hagler, and respond to the complainant or inquirer as to the results of the investigation and resolution.

If the inquiry is a complaint, the person shall be advised of his/her right to file a complaint with HHS and notified that the complaint must be filed within 180 days of the date of the alleged violation.

A COPY OF OUR PRIVACY POLICY IS POSTED IN OUR OFFICE AND AVAILABLE UPON REQUEST.

I HEREBY ACKNOWLEDGE THAT I HAVE READ A COPY OF THE PRIVACY POLICY.

________________________________ ________________

PATIENT/GUARDIAN DATE

____

PRINT PATIENT NAME