Save Print Email Start over

Dr. Alex JOHNSON Orthodontics

For Patients Under Age 18

Thank you for choosing our office for your orthodontic consultation. We look forward to speaking with you and addressing your orthodontic concerns. Our goal is to provide you with the best possible care and treatment. Please carefully complete the enclosed medical and dental information so that we may be of better service to you. Thanks!

PATIENT

First Name	Middle Name	Last Name		Today's Date	
Nickname	Birthdate	Age	Gender	SS#	
Address		City		State	Zip
Main Phone #		2nd/Cell Phone#			
Physician		Dentist			
School	Grade	Email Address			
Names and ages of other children in family					
Names of other family members in our orthodontic practice					
Who has legal custody of the patient?					

PARENT/GUARDIAN

First Name	Middle Name	Last Name	Gender	
Relationship to Patient		DOB Age	SS#	
Home Address		City	State	Zip
Main Phone #	2nd/Cell Phone#	Work Phone#		
Email Address		Work Email Address		
Driver's License #				
Employer		Occupation		
Employer Address		City	State	Zip

SECOND PARENT/GUARDIAN

First Name	Middle Name	Last Name	Gender	
Relationship to Patient		DOB Age	SS#	
Home Address		City	State	Zip
Main Phone #	2nd/Cell Phone#	Work Phone#		
Email Address		Work Email Address		
Driver's License #				
Employer		Occupation		
Employer Address		City	State	Zip

FINANCIAL & INSURANCE

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

First Name	Middle Name	Last Name	Gender	
Relationship to Patient		DOB Age	SS#	
Billing Address		City	State	Zip
Main Phone #	2nd/Cell Phone#	Work Phone#		
Email Address		Work Email Address		
Driver's License #				
Employer		Occupation		
Employer Address		City	State	Zip

INSURANCE INFORMATION

Dental Insurance Company		Phone #		
Insurance Company Address		City	State	Zip
Name of Insured	DOB	SSN/ID#	Group/Policy#	

MEDICAL HISTORY

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Is the patient in good health?
☐	☐	☐	Presently under care of a physician for a major illness?
☐	☐	☐	Any history of a major illness?
☐	☐	☐	Cardiovascular problem (heart defects, heart murmur, heart trouble, valve issues, or rheumatic heart disease)? Cardiologist: _____
☐	☐	☐	Antibiotic pre-medication needed for dental procedures?
☐	☐	☐	Rheumatic fever?
☐	☐	☐	Acid reflux issues?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Birth defects or hereditary problems?
☐	☐	☐	Emotional issues, anxiety, or depression?
☐	☐	☐	Autism, Asperger's or sensory issues?
☐	☐	☐	Cerebral palsy?
☐	☐	☐	Down syndrome?
☐	☐	☐	Any physical or emotional limitations?
☐	☐	☐	History of Eating Disorders/Bulimia/Anorexia?
☐	☐	☐	Seizures, Epilepsy, fainting spells, neurologic problems?
☐	☐	☐	Cancer, tumor, radiation, or chemotherapy?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Immune system problems?
☐	☐	☐	Excessive bleeding, bruising, anemia, or hemophilia?
☐	☐	☐	Chest pain, shortness of breath, or tire easily?
☐	☐	☐	Angina, arteriosclerosis, stroke, or heart attack?
☐	☐	☐	History of osteoporosis or osteopenia?
☐	☐	☐	Rheumatoid, osteoarthritis, or arthritic conditions?
☐	☐	☐	Bone disorders, bone fractures or major bone injuries?
☐	☐	☐	Ever taken oral or IV bisphosphonates such as Fosamax, Actonel, Boniva, Skelid, or Didronel for bone disorders?
☐	☐	☐	Vision, hearing problems, or skin disorders?
☐	☐	☐	Frequent colds, ear or throat infections?
☐	☐	☐	Asthma, sinus problems, or hay fever?
☐	☐	☐	Tonsil or adenoid issues?
☐	☐	☐	Gonorrhea, syphilis, herpes, or other STDs?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, or pneumonia?
☐	☐	☐	Diagnosed with ADD, ADHD?
☐	☐	☐	Poor attention span, difficulty focusing, hyperactive?
☐	☐	☐	Currently pregnant? (female patients)

If any of the above medical questions were answered 'Yes', please explain:

Any other medical conditions we should be aware of?

DENTAL HISTORY

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Concerned about under or over developed jaw?
☐	☐	☐	Concerned about spaced, crooked or protruding teeth?
☐	☐	☐	Erupting teeth very early or very late?
☐	☐	☐	Primary (baby) teeth removed that were not loose?
☐	☐	☐	Permanent or extra teeth removed?
☐	☐	☐	Supernumerary or congenitally missing teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Any lost or broken fillings?
☐	☐	☐	Teeth treated with root canals or pulpotomies?
☐	☐	☐	Frequent canker sores or cold sores?
☐	☐	☐	Teeth causing irritation to lip, cheek, gums?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking or grinding noises in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Been diagnosed or treated for TMJ or TMD problems?
☐	☐	☐	Difficulty when chewing, jaw opening or TMJ issues?
☐	☐	☐	Pain, tenderness, or noise in either jaw joint?
☐	☐	☐	Neck/shoulder pain?
☐	☐	☐	Appliance for teeth grinding or jaw joint pain/noise?
☐	☐	☐	Ever been diagnosed with gum disease?
☐	☐	☐	Ever had gum treatment or surgery?
☐	☐	☐	Jaw fractures, cysts, or infections?
☐	☐	☐	Chipped, injured primary (baby) or permanent teeth?
☐	☐	☐	Prior trauma or injury to the teeth, face, or neck?
☐	☐	☐	Has an orthodontist been previously consulted?
☐	☐	☐	Has the patient ever had orthodontic treatment? (list below)
☐	☐	☐	Has either parent had orthodontic treatment?
☐	☐	☐	Does the patient play contact sports?
☐	☐	☐	Does the patient play musical instruments?
☐	☐	☐	Has the patient been seen by their dentist recently? When? _____ What was done?_____ When scheduled to return?_____ How often does the patient see the dentist?_____

If any of the above medical questions were answered 'Yes', please explain:

Please list any medications, nutritional supplements, herbal medications or non-prescription medications, including fluoride supplements that are currently being taken and what they are being taken for.

MEDICATION	REASON

AIRWAY/MYOFUNCTIONAL

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Difficulty breathing through nose? (stuffy nose)
☐	☐	☐	Mouth breathing during day?
☐	☐	☐	Mouth breathing while sleeping?
☐	☐	☐	Have a dry mouth on waking up in the morning?
☐	☐	☐	Drools while sleeping?
☐	☐	☐	Snores? ☐ occasional ☐ often ☐ routine ☐ seasonal ☐ when sick ☐ snores loudly
☐	☐	☐	Heavy or loud breathing while sleeping?
☐	☐	☐	Difficulty falling asleep or staying asleep?
☐	☐	☐	Is sleep unrefreshing or are bedsheets a mess?
☐	☐	☐	Frequently tired during the day?
☐	☐	☐	Ever had a sleep study? When?
☐	☐	☐	Ever been diagnosed with sleep apnea?
☐	☐	☐	Ever had myofunctional therapy?
☐	☐	☐	Oral habits, thumb, fingers, pencils, pens, other?
☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	History of speech problems or speech therapy? ☐ currently ☐ previously age:

Please include any other pertinent information below:

DISCUSSION PRIVACY

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Is patient adopted? Is this kept private from the patient? ☐ Yes ☐ No
☐	☐	☐	Would you prefer any potential treatment be discussed without your child present?
☐	☐	☐	Is there anything that should not be discussed in front of your child?

Please include any other pertinent information below:

ALLERGIES

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Seasonal allergies?
☐	☐	☐	Routine allergies?
☐	☐	☐	Local anesthetics? (novocaine, lidocaine)
☐	☐	☐	Latex allergies? (gloves, balloons)
☐	☐	☐	Antibiotics or other medications? (list below)
☐	☐	☐	Metals? (jewelry, clothing snaps)
☐	☐	☐	Acrylics?

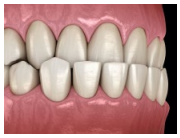
Please list any other allergies below:

SURGERIES

Yes	No	dk/u	dk/u = don't know/unknown	
☐	☐	☐	Tonsillectomy?	Age:
☐	☐	☐	Adenoidectomy?	Age:
☐	☐	☐	Nasal or Sinus?	Age:
☐	☐	☐	Cleft Lip/Palate?	Age:
☐	☐	☐	Frenectomy?	Age/Type:

Please include any other pertinent information below:

GROWTH STATUS

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Has the patient grown in the past year or has their shoe size or pant length changed recently?
☐	☐	☐	Is there a known history of any family member with an underbite? If yes, what is the relationship to the patient? 
☐	☐	☐	If a child, has the patient reached puberty?
☐	☐	☐	If a girl, has she started her menstruation? Age? _____

Please include any other pertinent information below:

We always appreciate the referral of patients to our office and like to thank those who have made the referral. Whom may we thank for referring you to our office? _____

Why are you seeking this consultation?

- ☐ to correct overbite
- ☐ to close spaces
- ☐ to straighten the teeth
- ☐ to improve facial proportions
- ☐ to improve general appearance
- ☐ to eliminate facial pain
- ☐ to help clicking jaw
- ☐ to correct jaw problem
- ☐ to correct the crossbite
- ☐ to address airway issues
- ☐ to develop the airway
- ☐ other (please be specific) _____

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in the health status of the patient. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Authorization is hereby granted for the orthodontic consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent. I authorize release of any information regarding the orthodontic treatment to my dental and/or medical insurance company.

Date _____

Signature _____ Relationship to Patient _____

Legal Guardian *(if different)* _____

ALEX J. JOHNSON, D.M.D., M.S.

Practice limited to orthodontics

(727) 786-7550

Acknowledgement of Receipt Notice of Privacy Practices (NOPP)
Authorization for Use & Disclosure of Protected Health Information (PHI)

I, _____, hereby authorize
(Guardian Name if Patient is Under Age 18 – or Patient Name)

Dr. Alex J. Johnson (hereafter collectively referred to as "Practice") to disclose related information concerning _____.
(Patient Name)

A copy of this signed, dated Authorization shall be as effective as the original.

The practice may use and disclose the Protected Health Information (PHI) to:

Mother	_____	**Father**	_____
Grand Mother	_____	**Grand Father**	_____
Nanny	_____	**Sibling's**	_____
Spouse	_____	**Other**	_____

(Person's to whom we may disclose information in your absence and relationship to you)

For the purpose(s) of (be specific): obtaining information and making appointments in my absence in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Authorization shall be as effective as the original. I release, hold harmless and agree to indemnify Dr. Alex J. Johnson PA, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Authorization. I specifically authorize Practice to use and disclose verbally, by mail, fax or encrypted e-mail, the following types of super-confidential information as stated in the NOPP **(check where appropriate)**:

☐ Orthodontic Treatment ☐ Progress ☐ Treatment Issues
☐ Make Appointments ☐ Patient Financial Account Information
☐ Insurance Status and/or Payments

Florida law requires your specific authorization to allow any communication of the patient's confidential information with the patient's Authorized Patient Representatives named above.

Signature: _____ _____
(Guardian or Patient) (Date)

Dr. Alex J. Johnson, DMD, MS

3840 Tampa Road, Palm Harbor, FL
727-786-7550

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Dr. Alex Johnson and (hereafter
(guardian name if patient is under the age of 18)
referred to as "Practice") to use and disclose the entire medical record concerning

_____ in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

☐ HIV records (including HIV test results) and sexually transmissible diseases

☐ Alcohol and substance abuse diagnosis and treatment records

☐ Psychotherapy records

COMPLETE AS APPLICABLE:

Describe the records you wish to access (x-ray, charting, etc.) and the approximate date range if applicable:

_____

Describe what you would like for use to do with your records (check all that apply):

☐ I wish to physically pick up a hard copy of the requested records

☐ I wish for you to mail a hard copy of the records to the following person or health care provider:

_____

☐ If the records are in electronic designated records, I wish to get an electronic copy of the requested records emailed to the following address (please print clearly):

_____@ _____._____

[*I understand there are risks that information in an unencrypted email could be read by a third party. My records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law]*

☐ I acknowledge I will be charged copying costs in the amount of $_____.

By Patient (or legal guardian): _____
(patient or guardian signature)

Patient's DOB: _____ Todays Date: _____