

# Welcome to Copus Orthodontics

We would like to welcome you and your child to our office. In an effort to provide the best service possible. We ask that you fill out this form as completely as possible. Thank you for your cooperation.

## 1. Patient Information-Youth

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

(First) (Middle) (Last)

Nickname (if preferred) \_\_\_\_\_ Male or Female Patient's Home Phone \_\_\_\_\_

Patient's Home Address \_\_\_\_\_ City, State ,Zip \_\_\_\_\_

Patient's school and grade \_\_\_\_\_

Please list any hobbies,sports and or musical instruments played \_\_\_\_\_

Patient's General Dentist: \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Have we treated another member of your family? YES or NO If YES,please list \_\_\_\_\_

Who is filling in this form? \_\_\_\_\_ Relationship to patient \_\_\_\_\_

## 2. Parent's/Guardian's Information

**MOTHER:** Marital Status (circle one) Single Married Widowed Divorced Separated Domestic Partner

Mother Step Mother Guardian Name \_\_\_\_\_  
(First) (Middle) (Last)

Address \_\_\_\_\_ City,State,Zip \_\_\_\_\_

SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_

Work phone \_\_\_\_\_ May we contact you at work? YES or NO

**FATHER:** Marital Status ( circle one) Single Married Widowed Divorced Separated Domestic Partner

Father Step Father Guardian Name \_\_\_\_\_  
(First) (Middle) (Last)

Address \_\_\_\_\_ City, State,Zip \_\_\_\_\_

SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_ Work

May we contact you at work? YES or NO

**3. DENTAL INSURANCE**

Does this policy cover Orthodontics?    YES    NO    I don't know

*If you have answered NO to the above question, you do NOT need to complete the remaining Insurance questions.*

**PRIMARY POLICY INFORMATION:**

INSURANCE CO. NAME \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Birth Date \_\_\_\_\_  
Relationship to the patient \_\_\_\_\_ Policy Holder's SS# \_\_\_\_\_  
Policy Holder's Employer \_\_\_\_\_

**SECONDARY POLICY INFORMATION:**

INSURANCE CO. NAME \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Birth Date \_\_\_\_\_  
Relationship to the patient \_\_\_\_\_ Policy Holder's SS# \_\_\_\_\_  
Policy Holder's Employer \_\_\_\_\_

**4. FINANCIALS**

**I understand by bringing in my child/step-child for the consultation, I am responsible for the treatment payment independent of what a divorce decree may state. Payment/Reimbursement must be made between the divorced parents. Copus Orthodontics will not intervene.**

**I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any personal, medical or insurance changes.**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Required)

**I HEREBY AUTHORIZE ORTHOBANC, LLC, ON BEHALF OF DAVID T. COPUS DDS MS PC TO OBTAIN A COPY OF MY CREDIT REPORT FROM A CREDIT REPORTING AGENCY FOR THE PURPOSE OF CONSIDERING PAYMENT OPTIONS.**

Signature \_\_\_\_\_ date \_\_\_\_\_  
(Optional)

Please list any additional people whom we may share the patient's treatment, scheduling and financial information with.  
Due to the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") any person not specifically named on this form will NOT be able to obtain any information.

Name:

Relationship to the patient:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Child Dental/Medical Health History Form

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 (first) (middle) (last)

### GENERAL

**YES NO**

- Does your child follow directions well?
- Does your child have a learning disability or need extra help with instructions?
- Is your child sensitive or self-conscious?
- Are you aware that some appointments will be during school / work hours?

Have there been any injuries to your child's face, mouth, teeth or chin?  
 If yes, please explain: \_\_\_\_\_

Have any teeth been removed by extraction? If yes, please explain: \_\_\_\_\_

Has anyone else in your family received orthodontic treatment? If yes, how did they feel about the results? \_\_\_\_\_

### DENTAL

**YES NO**

- Is your child presently in any dental pain?
- Has your child ever experienced an unfavorable reaction to dentistry?
- Has your child ever knocked out or chipped any teeth?
- Has your child ever been informed of extra or missing teeth?
- Is any part of your child's mouth sensitive to temperature or pressure?
- Does your child brush his / her teeth daily?
- Does your child floss regularly?
- Do your child's gums bleed when he / she brushes?
- Does your child predominantly breathe through his / her mouth?
- Does your child require any pre-medication for dental procedures?
- Does your child have any kind of finger / thumb or tongue habit?
- Has your child ever had any pain / tenderness in his / her jaw (TMJ / TMD)?
- Is your child aware of any jaw clicking or popping?
- Has your child been told that he / she clenches or grinds his / her teeth?
- Has your child ever experienced chronic ringing in his / her ears?
- Does your child have "tension" headaches?
- Does your child have any difficulty chewing or swallowing food?
- Does your child's bite feel uncomfortable?

What is your child's (or parent's) primary concern with his / her teeth? \_\_\_\_\_

Indicate your child's feelings / attitude towards having orthodontic treatment:

- Wants treatment     Treatment is necessary
- Unwilling but agrees     Uncooperative

Has an orthodontist been previously consulted? \_\_\_\_\_

Are you aware of any dental work that needs to be completed prior to orthodontic treatment? \_\_\_\_\_

Date of your child's most recent dental examination: \_\_\_\_\_

### MEDICAL

**YES NO** Has your child ever had any of the following diseases or medical conditions?

- Abnormal Bleeding / Hemophilia
- Anemia
- Arthritis
- Asthma or Hayfever
- Blood Disorders
- Congenital Heart Defect
- Depression/Mental Illness
- Diabetes
- Dizziness
- Epilepsy
- Gastrointestinal Disorders
- Heart Problems
- Heart Murmur
- Hepatitis / Liver Problems
- Herpes
- High Blood Pressure
- HIV+ / AIDS
- Kidney Problems
- Pneumonia
- Prolonged Bleeding
- Radiation / Chemotherapy
- Rheumatic Fever
- Tuberculosis
- Tumor or Cancer

Does your child have any other medical conditions not described above?  
 If yes, please explain: \_\_\_\_\_

(continued...)

(continued...)

**YES NO Is your child allergic to any of the following?**

- Penicillin
- Erythromycin
- Dental Anesthetics
- Aspirin
- Tetracycline
- Codeine
- Latex
- Metal

Has your child ever had to take antibiotics prior to a dental visit / checkup? \_\_\_\_\_

Has your child been diagnosed with any emotional disorders, including ADD / ADHD? If yes, please list any medications: \_\_\_\_\_

Please list any other medications to which your child has had an allergic reaction: \_\_\_\_\_

Please list all medications that your child is currently taking: \_\_\_\_\_

Is your child currently under the care of a physician? If yes, please explain: \_\_\_\_\_

Please explain any medical problems that your child has had in the past: \_\_\_\_\_

I have read and I understand the above questions. 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.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical / dental status.

We will discuss your treatment with parents / legal guardians / the person financially responsible for your treatment / referring Doctor / Dentist for the the furtherment of your treatment.

\_\_\_\_\_  
Signature of parent / legal guardian Date

## Medical History Updates or Changes

Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_ Comments: \_\_\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Thank you for filling out this form completely. It will enable us to help you more effectively.  
If you have any questions, please do not hesitate to ask us. We are always happy to help.

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

# Photo & video Release Form For Copus Orthodontics

I hereby grant Copus Orthodontics permission to use my likeness in a photograph in any and all of its publications, including website and all social media entries, without payment or any other consideration.

I understand and agree that these materials will become the property of Copus Orthodontics and will not be returned.

I hereby irrevocably authorize Copus Orthodontics to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing Copus Orthodontics or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Copus Orthodontics from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

\_\_\_\_\_  
(Date) \_\_\_\_\_ (Signature)

\_\_\_\_\_  
(Printed Name) (Date)

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:  
I hereby certify that I am the parent or guardian of \_\_\_\_\_, named above,  
and do hereby give my consent without reservation to the foregoing on behalf of this person.

\_\_\_\_\_  
(Parent/Guardian's Signature) (Date)