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_____

(Flirst) (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:
_____	_____
_____	_____

CopusOrthodontics

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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_____