



Hi,

Thank you for selecting Saddle Creek Orthodontics for your orthodontic treatment needs!

Your visit will involve a comprehensive orthodontic examination, including any necessary orthodontic records. If treatment is recommended, we will have plenty of time to discuss the treatment plan, the estimated treatment time and the fees associated with this service.

If you have insurance that covers orthodontic treatment, please make sure we have that information before the day of your examination so we can give you an estimated benefit during the appointment.

We have included some important forms with this letter. Please complete them ahead of time and bring them with you to your next appointment.

We are looking forward to a relaxed and pleasant visit with you. Please call or visit our website at www.SaddleCreekOrtho.com for directions or for more information about our practice. We will see you soon.

Sincerely yours,

The Doctor and Staff of
Saddle Creek Orthodontics

PATIENT INFORMATION - YOUTH

Date _____

Patient's Legal Name _____ Preferred Name _____

DOB _____ Gender _____ School/Grade _____

Hobbies/Interests _____

Referred By _____ General Dentist _____

Past or Present Family Members in Treatment _____

Have you Consulted an Orthodontist Before? _____

PARENT/GUARDIAN INFORMATION

Mother's Name _____ DOB _____

E-Mail Address _____ Marital Status/Spouse's Name _____

Address _____ Phone _____

Employer _____ Occupation _____

Father's Name _____ DOB _____

E-Mail Address _____ Marital Status/Spouse's Name _____

Address _____ Phone _____

Employer _____ Occupation _____

INSURANCE INFORMATION

Subscriber's Name _____ DOB _____

Address _____ Phone _____

Employer _____

Insurance Company _____ Phone _____

Group Number _____ Subscriber ID/SS# _____

Signature _____ Date _____
(Parent/Legal Guardian)

MEDICAL HISTORY

Patient's Name _____ Date _____

Dentist's Name _____ Date of Last Dental Exam _____

Physician's Name _____ Date of Last Physical Exam _____

Allergies or reactions to any of the following:

- | | | |
|---------------------------------------|---|------------------------|
| Y _ N _ Aspirin, Ibuprofen or Tylenol | Y _ N _ Local anesthetics | Y _ N _ Sedatives |
| Y _ N _ Barbiturates | Y _ N _ Metals | Y _ N _ Sleeping pills |
| Y _ N _ Codeine or other narcotics | Y _ N _ Penicillin or other antibiotics | Y _ N _ Sulfa drugs |
| Y _ N _ Latex | Y _ N _ Plastic or vinyl | Y _ N _ Other _____ |

Medications:

Please list medications, nutrient supplements, herbal medications & non-prescription medicines currently being taken:

Medication	Taken For

Now or in the past, has the patient had:

- | | |
|--|---|
| Y _ N _ Adenoids or tonsils removed | Y _ N _ Muscular dystrophy |
| Y _ N _ Arteriosclerosis (hardening of the arteries) | Y _ N _ Nighttime breathing problems (snoring or sleep apnea) |
| Y _ N _ Asthma, hay fever, sinus trouble or hives | Y _ N _ Nervousness |
| Y _ N _ Autoimmune disorders or immune system problems | Y _ N _ Neuralgia |
| Y _ N _ Bleeding or bruising easily | Y _ N _ Osteoarthritis (stiff or swollen joints) |
| Y _ N _ High or low blood pressure - please circle | Y _ N _ Osteoporosis |
| Y _ N _ Cancer, tumor, chemotherapy or radiation treatment | Y _ N _ Parkinson's disease |
| Y _ N _ Chronic fatigue | Y _ N _ Prior orthodontic treatment |
| Y _ N _ Current pregnancy | Y _ N _ Psychiatric care |
| Y _ N _ Depression or other mental health disturbance | Y _ N _ Rheumatic fever |
| Y _ N _ Diabetes | Y _ N _ Rheumatoid arthritis |
| Y _ N _ Dizziness | Y _ N _ Scarlet fever |
| Y _ N _ Epilepsy or other seizure disorder | Y _ N _ Skin disorder |
| Y _ N _ Fibromyalgia | Y _ N _ Speech difficulties |
| Y _ N _ General anesthesia | Y _ N _ Stroke or heart attack |
| Y _ N _ Hearing impairment | Y _ N _ Tuberculosis |
| Y _ N _ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations) | Y _ N _ Wisdom teeth extraction |
| Y _ N _ Frequent coughs, colds or sore throats | Y _ N _ Birth defects or hereditary problems |
| Y _ N _ Hemophilia | Y _ N _ Endocrine or thyroid problems |
| Y _ N _ Hepatitis, AIDS or HIV positive | Y _ N _ Stomach ulcer or hyperacidity |
| Y _ N _ Injury to face, neck, mouth or teeth - please circle | Y _ N _ Polio, mononucleosis or pneumonia |
| Y _ N _ Insomnia | Y _ N _ Vision problems |
| Y _ N _ Jaw joint surgery | Y _ N _ Loss of weight recently, poor appetite |
| Y _ N _ Kidney or liver problems | Y _ N _ Eating disorder (anorexia or bulimia) |
| Y _ N _ Meniere's disease | Y _ N _ Chest pain, shortness of breath or swelling ankles |
| Y _ N _ Multiple sclerosis | Y _ N _ Frequent or severe headaches |
| | Y _ N _ Other condition |

Emergency Contact _____ Relationship _____ Phone # _____

Patient/Parent Signature _____ Today's Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient's Legal Name _____

Section B: To the Patient - Please Read these Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request with this Consent. We encourage you to read it carefully and completely before signing this consent.

Office Procedures: As a part of the practice procedures our doctors reserve the right to use patient photographs, x-rays, videos and other photographic reproductions for the purpose of professional academic education and practice promotion, including use on website, brochures and social media sites.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will make available upon request a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person:	Anna Fagala
Telephone:	901.726.3878
Email:	SaddleCreekOrtho@gmail.com
Address:	2176 West St Suite 320 Germantown, TN 38138

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Section C: Signature

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient/Parent Signature _____ Today's Date _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT