PARK CITIES
ORTHODONTICS

WELCOME TO PARK CITIES ORTHODONTICS!

Please complete the new patient registration form below and bring it with you to your initial new patient appointment.

Patient Information

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____

Phone Number: _____ Full Street Address: _____ Gender: M/F/Other: _____

Primary Phone Number: _____ Email Address: _____

How did you hear about our office?: _____ Reason for Consultation: _____

Has the patient been examined by an orthodontist before: _____ Date of last cleaning: _____

Insurance Information

Insurance Name: _____ Insurance Phone Number: _____Member ID#: _____

Group#: _____ Subscriber First Name:_____ Last Name: _____

Full Address of Subscriber:_____ Date of Birth of Subscriber: _____

Medical Information

Sleep/Airway Issues

Does the patient tend to be a mouth-breather? **Yes / No**
Does the patient snore at night? **Yes / No**
Has the patient seen an ear, nose or throat specialist? **Yes / No**
Is the patient using a sleep apnea device? **Yes / No**

Medical History

ADHD/AD **Yes / No**
AIDS/HIV **Yes / No**
Anemia **Yes / No**
Arthritis **Yes / No**
Asthma **Yes / No**
Autism **Yes / No**
Bone Disorder **Yes / No**
Cancer **Yes / No**
Cerebral Palsy **Yes / No**
Chest Pain **Yes / No**
Chronic Neck Pain **Yes / No**
Cold Sores/Herpes **Yes / No**
Diabetes **Yes / No**
Down Syndrome **Yes / No**
Endocrine Problems **Yes / No**
Emotional Disorder **Yes / No**
Epilepsy **Yes / No**
Headaches **Yes / No**
Heart Condition **Yes / No**
Hepatitis **Yes / No**
Ear Pain **Yes / No**
Immune Problems **Yes / No**
Kidney Problems **Yes / No**
Low Blood Pressure **Yes / No**
Muscular Disorders **Yes / No**
Nervous Disorders **Yes / No**
Osteoporosis **Yes / No**
Prolonged Bleeding **Yes / No**
Scoliosis **Yes / No**
Seizures **Yes / No**
Sinus Problems **Yes / No**
Tuberculosis **Yes / No**

Dental History

Clicking of Jaw **Yes / No**
Jaw Pain **Yes / No**
Painful Chewing **Yes / No**
Periodontal Problems **Yes / No**
TMJ Problems **Yes / No**
Do your gums bleed when you brush? **Yes / No**
Is the patient seeing any other dental specialists? **Yes / No**
Cancer **Yes / No**
Any diseases or problems not mentioned above? **Yes / No**
Any dental restorations needing to be completed? **Yes / No**
Have there ever been any injuries to the face, mouth or chin? **Yes / No**
Have you ever lost or chipped any teeth? **Yes / No**
Is any part of your mouth sensitive to temperature or pressure? **Yes / No**
Allergic to Latex? **Yes / No**
Is the patient currently pregnant? **Yes, Due Date: _____ / No**
Have adenoids been removed? **Yes, when?: _____ / No**
Have tonsils been removed? **Yes, when?: _____ / No**
Emotional Disorder **Yes / No**
Currently taking any mecations? **No / Yes, List here:**
_____
_____
_____

Allergies? Yes / No
Explain: _____
_____
_____
_____

Are antibiotics necessary prior to treatment? Yes / No
List Here: _____
_____
_____
_____

Authorization

I understand the information given is correct and will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in the patient's medical status.

I hereby authorize this office to perform an oral evaluation and consent to the taking of x-rays, photographs and other records (if necessary) to determine appropriate orthodontic treatment on the above-named patient.

I also authorize this office to leave messages about appointments on my voice mail or answering machine, and agree to receive e-mail reminders and text messages about appointments.

Signature of Patient, Parent, or Guardian: _____ **Relationship to patient:** _____ **Date:** _____

If someone other than the parent(s) or guardian(s) listed above will be bringing the patient to appointments, **please list here:**

_____

COVID-19 Treatment Consent Form

1. **I willingly and knowingly consent** to dental treatment by Park Cities Orthodontics, including any designated associates and team members during the COVID-19 pandemic.

2. **I understand** that Park Cities Orthodontics is observing the guidelines from the Centers for Disease Control and Prevention for its recommended treatment and infection control protocols.

3. **I am not aware** of any risk whereby I might be infected or a possible carrier of COVID-19. I confirm that I have not tested positive for COVID-19 in the last 30 days, and I am not presenting any of the following symptoms of COVID-19:
A. Fever of 100.5 degrees Fahrenheit (or 37 degrees Celsius) or higher
B. Shortness of breath
C. Dry cough
D. Runny nose
E. Sore throat.
F. Diminished sense of taste and smell

4. **I confirm** that I am not aware of being in close contact (6 feet or fewer) in the last 14 days for 15 minutes or more with anyone who has tested positive for being infected with COVID-19. Nor have I knowingly been in contact with anyone who has the symptoms stated above in the last 14 days.

5. **I confirm** that I have not traveled outside the United States in the past 14 days. I can confirm that I have not traveled domestically via commercial airline, train, bus or any other public transport within the past 14 days.

6. **I understand** that COVID-19 has a substantial incubation period in which carriers of the virus may not demonstrate symptoms while still being highly contagious. I understand that it is not possible to determine which individuals are infected and which are not, given the current limitations and availability of COVID-19 testing. I understand that several dental procedures create water spray, which is one method in which the virus can be spread. I understand that the ultra-fine, mist-like nature of the water spray can linger in the air for hours, which can transmit COVID-19.

7. **I understand** that, due to the frequency of the visits from other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I may have an elevated risk of contracting COVID-19, simply by being present in a dental office, even though the recommended guidelines from the Centers for Disease Control and Prevention and the local health department are being observed.

8. **Informed Consent:** I acknowledge that I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 while visiting the dental office and while receiving dental procedures. I reaffirm that I am not a knowing carrier of COVID-19, nor have I been exposed to or infected with COVID-19, to the best of my knowledge. I do voluntarily assume any and all reasonable medical / dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment, as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the prescribed dental procedures have been explained to me, as needed, and I have also been given the opportunity to ask questions.

Signature: _____

The information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes.

Patient Name: _____ **Signature of Patient, Parent or Guardian:** _____ **Date:** _____

Doctor Information

Name of Practice: _____ **Doctor Name:** _____

Phone/Mobile: _____ **Doctor Practice Address:** _____