New Patient Registration

Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date: ________/________/_______

PATIENT INFORMATION

Patient's Legal Name: ______________________________________ Preferred Name:__________________ Male ☐ Female ☐

Last First

Date of Birth:_____/_____/________ Parent/Guardian:___________________________ Relationship:_______________________

Last First

Address:________________________________ City:______________________ State:_________ Zip Code:__________________

Home Phone:(______)______-____________ Cell Phone:(______)______-____________ Email:__________________________

Marital Status:__________________ School:_________________________

Emergency Contact Name:__________________________ Phone:(______)______-____________ Relationship:______________

Last First

How did you first hear about Leland Orthodontics?____

Other Family Members seen by us:____

DENTIST INFORMATION

Current Dentist: Dr. ____________________ Dental Office:______________________Office Location:______________________

Last Visit Date: _____/_____/________ Pending Dental Treatment:____

FINANCIAL INFORMATION

Person Financially Responsible:_____________________________________ Relationship to Patient:______________________

Last First

Phone:(______)______-____________ Address (if different than patient's):_________________________ City:______________

State:_________ Zip Code:______________ SS#:_______-_______-________

INSURANCE INFORMATION (if applicable): Please provide the front desk with your insurance card and Driver's License

☐ I will not be using insurance

☐ I do not know if I have orthodontic coverage, please verify.

Insurance Company:_______________________ ID#:________________________________ Group #:_____________________

Insurance Phone #:(______)______-__________ Policy Holder:______________________________

Last First

Policy Holder Date of Birth:_____/_____/________ SS#:_______-_______-________ Employer:____________________________

Address (if different than patient's):_______________________ City:______________State_________ Zip Code:______________

ORTHODONTIC GOALS

What concerns you about your teeth?____

Have you ever received Orthodontic treatment in the past? If yes, when/where?____

Do you have any problems sleeping? Any snoring or trouble breathing? Please explain:___________________________________

LELAND ORTHODONTICS

New Patient Registration

After your consultation, we can usually get you started with treatment that same day! Do you have time in your schedule to stay for treatment?

☐ Yes! ☐ I plan on coming back a different day to start treatment. ☐ Unsure.

MEDICAL INFORMATION *Your medical information is for office records only and is confidential.*

		Now or in the past have you had:
YES	**NO**	**PLEASE CHECK ALL**
		Birth defects or hereditary problems?
		Any injuries to face, neck, head?
		Endocrine or thyroid problems?
		Diabetes or low blood sugar?
		Cancer, tumor, radiation treatment, chemotherapy?
		Immune system problems?
		Gonorrhea, syphilis, herpes, sexually transmitted diseases?
		AIDS or HIV Positive?
		Polio, mononucleosis, tuberculosis, pneumonia?
		Seizures, fainting spells, neurologic problems?
		Mental health disturbance or depression?
		Vision, hearing or speech problems?
		History of eating disorder?
		High or low blood pressure?
		Excessive bleeding or bruising, anemia?
		Heart Defects? Strokes / Heart Attacks?
		Frequent headaches or migraines?
		Asthma, sinus problems, hayfever?
		Tonsil or adenoid condition?
		Do you frequently breathe through your mouth?

YES	NO	PLEASE CHECK ALL
		Do you chew or smoke tobacco?
		Are you pregnant or trying to become pregnant?
		Do you have a substance abuse problem?
		Do you take antibiotic premedication before any dental procedure?

Please list allergies (ex: latex, metals, local anesthetics):

____

Please list all medications:

____

Is there anything else in your medical history you would like us to know about?:

____

Are there any special considerations or requests to help better care for you and/or your child at Leland Orthodontics?:

____

____

DIVORCE, SEPARATION & CUSTODY MATTERS:

- **A.** We believe that such matters should not enter into a child's orthodontic treatment.
- **B.** We will not engage in or act as an intermediary between parties involved in family legal disputes. It is the responsibility of the individuals involved to manage any necessary communication related to their legal matters.
- **C.** "Joint Custody" means that each parent has equal access to the child's orthodontic care records. Without a court order, we will not stop either parent from having access to their child's chart, making an appointment or receiving advice.
- **D.** Subject to a court order to the contrary which has been provided to us, we will not call the absent parent for consent prior to treatment.
- **E.** We will discuss with the accompanying parent information pertinent to the child's history, present exam and proposed treatment.
- **F.** We reserve the right to charge an administration fee for copying records should the requests become excessive.
- **G.** We do not participate in or provide documentation for legal matters such as divorce, separation, or custody disputes. Our primary role is to support the health and well-being of our patients, and we remain neutral in all legal family matters.
- **H.** Should the issues that come between parents become disruptive to our organization, we will consider discharging the patient from further treatment.
- **I.** We will not be held responsible or liable for any decisions, outcomes, or actions related to legal disputes, including custody arrangements, visitation rights, or other family legal matters.
- **J.** We do not offer 'split' contracts. It is the responsibility of parents to manage and coordinate the division of financial obligations for treatment.

By signing below, you acknowledge and agree to this policy.

Signature:____ Date:_____/_____/________

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my healthcare/dental providers and my dental insurance company:

Signature:____ Date:_____/_____/________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature:____ Date:_____/_____/________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Patient's Full Name}

____
{Signature}

___________/_________/_______________
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify) ______________________________________

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