LITTLE STARS DENTISTRY
OF MIAMI SHORES

CHECK ONE:
Private Insurance: ____
HMO: ____
Medicaid ____
No Insurance: ____
Other: ____

PATIENT INFORMATION:

Date _____

Patient's name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Sex: _____ Social Security # _____

Address _____ State _____ City _____ Zip Code _____

Telephone Home: _____ Cell: _____ Work: _____ Other: _____

Email: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship to patient: _____ SS#: _____

Address: _____

Date of Birth: _____Telephone (Home): _____Cell: _____ Work: _____

Employer_____ Occupation _____

SECOND PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship to patient: _____ SS#: _____

Address: _____

Date of Birth: _____ Telephone (Home): _____ Cell: _____ Work: _____

Employer_____ Occupation _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Insured's DOB: _____

Insurance Co. Address: _____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes: _____

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Insured's DOB: _____

Insurance Co. Address_____ Phone No. _____

Reason for Orthodontic Consultation: _____
Referred by: _____
Family Dentist: _____ Telephone: _____
Last dental visit: _____

MEDICAL HISTORY

Is the patient health: Poor _____ Regular _____ Good _____ Excellent _____

Physician _____ Phone_____ Date of Last complete physical exam: _____

Is the patient taking any medication? _____

Is the patient allergic to any medication? _____

Does the patient have a tendency towards colds, sore throats or ear infections? _____

Have the tonsils and adenoids been removed? _____

Birth defects: _____

Has the patient reached puberty? _____ Girls: Has she started menstruation? _____

Boys: has his voice changed? _____

Is the patient presently under the care of a physician for Illness? _____

Does the patient have any history of major illness? _____

Is the patient pregnant? _____

CIRCLE (Yes) or (No) if the patient has or has had any of the following:

Asthma	Y N	Diabetes	Y N
Anemia	Y N	Dizziness	Y N
Arthritis	Y N	Epilepsy	Y N
Abnormal Bleeding	Y N	Hay Fever	Y N
Bone Disorders	Y N	Heart Murmur	Y N
Blood transfusion	Y N	Heart Problems	Y N
Bronchitis	Y N	Herpes	Y N
Bowel Syndrome	Y N	Hepatitis/ Liver problems	Y N
Congenital Heart Defect	Y N	High/ Low blood pressure	Y N
Convulsions	Y N	HIV / AIDS	Y N
Joint replacements	Y N	Stroke	Y N
Hyperactivity	Y N	Kidney problems	Y N
Pneumonia	Y N	Ulcer	Y N
Persistent cough	Y N	Rheumatic Fever	Y N
Scarlet Fever	Y N	Mental or nervous disorder	Y N
Tumor or Cancer	Y N	Problems with Immune system	Y N
Sexually transmitted disease	Y N	Sinus problems	Y N

Has the patient ever been told by a physician that he or she needs to PREMEDICATE before dental treatment? _____

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

DENTAL HISTORY

Has the patient had any orthodontic evaluation or treatment before? _____

Name of the orthodontist: _____

How many times the patient does brush his/ her teeth? _____

Have there been any injuries to the face, mouth or teeth? _____

Has the patient ever sucked their finger or thumb? _____ if so until what age? _____

Does the patient have any speech problems? _____

Is the patient a mouth breather while awake or asleep? _____

Has the patient been informed of any missing or extra permanent teeth? _____

Does the patient have any clicking or discomfort of the jaw joints? _____

Does the grind his/ her teeth? _____ Day or Night? _____

Does the patient play musical instruments with the mouth? _____

I hereby authorize Little Stars Dentistry of Miami Shores to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. I authorize my insurance company to pay Little Stars Dentistry of Miami Shores all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment services charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Little Stars Dentistry of Miami Shores. This consent is to remain in effect from the date indicated until canceled in writing.

Signature: _____ Date: _____

Patient Name: _____ Date: _____

Parent Signature: _____ Date: _____

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

MARTA ORTIZ-PEREZ, D.M.D. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **MARTA ORTIZ-PEREZ, D.M.D.**

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient