Standifer Orthodontics

Braces for Children & Adults

Dr. Denny Standifer

Patient:

First _____ Middle _____ Last _____

Name we should call you _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Birthdate _____ Social Security # _____

Employer/School _____

Mother:

First _____ Middle _____ Last _____

Name we should call you _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Birthdate _____ Social Security # _____

Employer _____

Father:

First _____ Middle _____ Last _____

Name we should call you _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Birthdate _____ Social Security # _____ _____

Employer _____

Other:

Parent's Marital Status _____ Patient Lives With _____

Patient Interests _____ Dentist _____

How did you learn about our office? _____

Dayton Office: (423) 775-9302 • 225 Main Street • Suite 100 • Dayton, TN 37321

Chattanooga Office: (423) 877-6485 • 1724 Hamill Road • Suite 202 • Hixson, TN 37343

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Patient _____ **Birthdate** _____

Medical

Check any conditions that apply. Physician _____

- ☐ Latex allergy
- ☐ Heart disorder
- ☐ Lung disorder
- ☐ Blood disorder
- ☐ Epilepsy/seizures
- ☐ Drug Allergy
- ☐ Rheumatic fever
- ☐ Allergies
- ☐ Diabetes
- ☐ Chronic Headache
- ☐ Pregnant
- ☐ Liver disorder
- ☐ Kidney disorder
- ☐ HIV/AIDS
- ☐ Psychiatric care
- ☐ Fainting
- ☐ Hepatitis
- ☐ Bone disorder
- ☐ Cancer
- ☐ ADD

- ☐ Currently under physicians care
- ☐ Antibiotics required for dental care
- ☐ Other medical conditions
- ☐ Currently taking medication
- ☐ Surgery within last 5 years
- ☐ None of these apply to patient

Explain any checked conditions _____

_____

_____

Dental

Dentist _____ Last cleaning _____

- ☐ Injury to the jaws or teeth
- ☐ Jaw joint problems/TMJ
- ☐ Missing/extra teeth
- ☐ Speech problems
- ☐ Prior orthodontic treatment or consult
- ☐ Gum disease /bleeding gums
- ☐ Clenching/grinding
- ☐ Wisdom teeth removed
- ☐ Thumb/finger sucking

Explain any checked conditions _____

_____

Your orthodontic concerns _____

_____

I certify that I have legal responsibility for this patient, that the information provided is accurate and that I will inform Standifer Orthodontics of any changes in this information.

Signature _____ Date _____

Reviewed by _____ Date _____

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Authorization for Credit Report

I authorize Standifer Orthodontics to obtain a credit report for the responsible party named below. I understand the information will be used by this office for making credit decisions related to orthodontic treatment.

Patient Name _____

Responsible Party Name First _____ Middle _____ Last _____

Social Security Number _____

Current Street Address _____ Years lived here _____

City _____ State _____ Zip _____

Current Employer _____ Years Employed _____

Employer City _____ State _____

If changed residence or employment in the last 24 months:

Previous Street Address _____ Years lived here _____

City _____ State _____ Zip _____

Previous Employer _____ Years Employed _____

Employer City _____ State _____

Signature _____ ***Date*** _____

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STANDIFER ORTHODONTICS

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 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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)_____