The Smile Questionnaire

Patient's name_____ Date _____

In order to accurately evaluate your needs and expectations please help us by answering the following questions.

Do you feel your teeth are:

- Too small or short? **Yes** **No**
- Too large or long? **Yes** **No**
- Crooked or crowded? **Yes** **No**
- Misshaped (uneven/pointed)? **Yes** **No**

Do you feel the front teeth are too far forward ("Buck Teeth")?

Yes **No**

Are there spaces between the teeth that you do not like?

Yes **No**

Do you see too much or too little gum tissue when smiling?

Yes **No**

Have you experienced previous orthodontic treatment (including braces, or other appliances)? **Yes** **No**

If so when? _____

Are there other issues not listed above that you would like to have changed?

Yes **No**

If yes please explain _____

Signature _____ **Relationship to Patient** _____

Date _____

Patient and Responsible Party Information

PATIENT INFORMATION:

Name: _____

DOB _____/_____/_____

Marital Status_____

S.S. #_____

Email: _____

Address _____

City _____

State_____ Zip _____

Home #_____

School/Employer: _____

School / Work # _____

Cell# _____

Insurance Co. _____

FAMILY INFORMATION: (If the patient is under 18)

Guardian/
Mother: _____

DOB _____/_____/_____

Marital Status_____

S.S. #_____

Email: _____

Address_____

City_____

State _____Zip_____

Home #_____

Employer: _____

Work #_____

Cell#_____

Insurance Co._____

Guardian/Spouse/
Father: _____

DOB_____/_____/_____

Marital Status_____

S.S. # _____

Email: _____

Address _____

City _____

State _____Zip_____

Home #_____

Employer: _____

Work # _____

Cell # _____

Insurance Co._____

Nearest relative _____ Their # _____

*I hereby authorize release of any information to/ from insurance agencies listed above. I authorize payments directly to Dr. Nicholas S. Ising otherwise payable to me. **I understand that I am responsible for the total cost of orthodontic treatment if insurance benefits change during the course of treatment.

_____ _____

Signature (responsible party) **Date**

DO NOT SIGN OFFICE USE ONLY:

***I have reviewed all the above information and nothing has changed since my last appointment.**

_____ _____

Signature (responsible party) **Date**

***I have reviewed all the above information and nothing has changed since my last appointment.**

_____ _____

Signature (responsible party) **Date**

Ising Orthodontics Medical History Form

Date_____ How did you hear about our office? _____

Patient's Name _____Patient's Dentist _____ Date of last Cleaning_____

Patient's Physician _____

Dental History

Prior orthodontic treatment?	Y	N
If yes, when and where?	Y	N
Any Periodontal (gum) problems?	Y	N
Any permanent teeth removed?	Y	N
Any problems with your jaw joints?	Y	N
Thumb sucking or finger sucking?	Y	N
Any injuries to teeth or facial bones?	Y	N
Mouth breathing, Snoring?	Y	N
Tongue thrusting?	Y	N
Sleep apnea/CPAP use?	Y	N

If you answered yes to any of the questions please explain: _____

_____

_____

_____

_____

_____

_____

_____

_____

Medical History

Any allergies to drugs, foods, or environment?	Y	N
Any birth defects?	Y	N
Any learning disabilities or ADD/ ADHD?	Y	N
Thyroid disease?	Y	N
Bleeding disorder or Hemophilia?	Y	N
Diabetes?	Y	N
Asthma?	Y	N
Arthritis?	Y	N
Heart Murmur or Mitral Valve Prolapse?	Y	N
Bisphosphonate use/Osteoporosis?	Y	N

Artificial heart valve?	Y	N
Liver or Kidney disease?	Y	N
Cancer?	Y	N
Growth disorder?	Y	N
Seizures?	Y	N
Tonsils or Adenoids problem?	Y	N
Latex Allergy?	Y	N
Prescription Medications?	Y	N
Nicotine usage?	Y	N
TB, HIV, Hepatitis, other infectious disease?	Y	N
Any other issues not listed?	Y	N

I have read and understand the above questions. I will not hold Dr. Ising or any member of his team responsible for any errors or omissions that I have made in the completion of this form; if there are any changes to this history record or dental/medical status I will inform this practice.

_____

Signature Date

OFFICE USE ONLY:

I have reviewed the above information and there are no changes; if there are changes I will inform this practice.

_____

Signature (responsible party) Date

I have reviewed the above information and there are no changes; if there are changes I will inform this practice.

_____

Signature (responsible party) Date

Dr. Nicholas S. Ising DMD, MS, PLLC
ORTHODONTIST

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A:

Patient's Name: _____

Patient's Address: _____

Telephone: _____ Email: _____

Patient Social Security Number: _____

Section B: TO THE PATIENT or Legal guardian – PLEASE READ THE FOLLOWING 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 use 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 accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 issue a revise Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

I, _____, have had the 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.

Signature: _____ Date: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of 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.

270-769-2186 (office) 270-982-2666 (fax)
E-mail: isingsmiles@gmail.com

Insurance Information

Primary Insurance Company Name: _____

Ins. Co. Phone: _____

Insurance Company Address: _____

State: _____ Zip Code: _____

Subscriber Name: _____

Social Security: _____

Member ID: _____

Group #: _____

Subscribers DOB: _____/_____/_____

Subscribers Place of Work: _____

Secondary Insurance Name: _____

Ins. Co. Phone: _____

Insurance Company Address: _____

State: _____ Zip Code: _____

Subscriber Name: _____

Social Security: _____

Member ID: _____

Group #: _____

Subscribers DOB: _____/_____/_____

Subscribers Place of Work: _____