Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Trevor Veltkamp. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices posted in the facility.

Dr. Trevor Veltkamp reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority				
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
Any member of my immediate family	☐	YES	☐	NO
Spouse Only	☐	YES	☐	NO
Other (Please Specify):	☐	YES	☐	NO

_____ _____

Name of Patient Signature of Patient or Responsible Party

_____ _____

Date Relationship to Patient (self, parent, guardian)

TREVOR T. VELTKAMP, DDS, MS, PS SPECIALIST IN ORTHODONTICS

3400 Squalicum Parkway Suite 105 Bellingham, WA 98225 (360) 676-2770 | Fax (360) 756-8946
1610 Grover Street C-1 Lynden, WA 98264 www.veltkamportho.com

Patient Information **Date:**

Patient's Name _____ Phone _____
Address _____ Zip _____ Email _____
Birthday ___/___/____ Age ____ Sex ____ Grade _____ School _____
Whom may we thank for referring you to our office? _____ Dentist _____
Siblings: Name _____ Age _____ Name _____ Age _____

Responsible Party Information

Father's Name (Or Guardian) _____ Single/Married/Divorced/Separated
Address _____ Zip _____ How long at this address? _____
Home Phone _____ Work Phone _____ Cell Phone _____ Email _____
Social Security Number ____-__-____ Birthdate ___/___/____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____

Mother's Name (Or Guardian) _____ Single/Married/Divorced/Separated
Address _____ Zip _____ How long at this address? _____
Home Phone _____ Work Phone _____ Cell Phone _____ Email _____
Social Security Number ____-__-____ Birthdate ___/___/____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____

Orthodontic Insurance Information

Policy Holder's Name _____ Birthdate ___/___/____ SSN ____-____-____
Insurance Company _____ Group No. _____
Insurance Co Address _____ Phone _____
Do you have Dual Coverage? Yes No
2nd Insured's Name _____ Birthdate ___/___/____ SSN ____-____-____
Insurance Company _____ Group No. _____
Insurance Co Address _____ Phone _____

If my dependent pursues treatment with Veltkamp Orthodontics, I authorize Veltkamp Orthodontics to bill and collect insurance funds on their behalf

Signature _____ Date _____

Dental History

1. Have there been injuries to the face, mouth, or teeth?	Yes	No
2. Has the patient ever had a thumb or finger sucking habit?	Yes	No
3. Does the patient have any speech problems?	Yes	No
4. Have you been informed of any missing or extra permanent teeth?	Yes	No
5. Has any previous orthodontic treatment been rendered?	Yes	No
6. Does the patient suffer from any jaw joint problems (pain, clicking, popping, etc.)?	Yes	No

Emergency Information

Name of Emergency Contact _____ Phone _____

Medical History

Name of Patient's physician_____ Date of Last Exam_____

1. Is this patient in good health? Yes No
2. Does the patient have any health problems? Yes No If yes, explain:_____
3. Are immunizations up to date? Yes No Do not know
4. Does patient have allergies to medications, medical products (latex), or to the environment (dust mites, pollen, etc.)?
   If yes, please list: _____
5. Please list current prescription medications taken by patient:_____
5. Has patient had any recent rapid growth? Yes No If yes, how much?_____
7. Is it likely that the patient will mature early or late? Early Late
8. Females: Has menstruation begun? Yes No If yes, when?_____
   Pregnant? Yes No Using birth control pills? Yes No
9. Has patient been treated by a physician for any of the following conditions? (check any that apply)

Yes	No		Yes	No		Yes	No	
		Problems at birth			Hepatitis/Liver Disease			Asthma
		Heart Disease/Murmur			Tuberculosis			Cleft lip/Palate
		Rheumatic fever			Kidney Disease			Speech or Hearing Problems
		Sickle Cell Anemia			Cancer/Radiation Therapy			Tonsil, Adenoid, Sinus Problems
		Anemia/Hemophilia			Cerebral Palsy			Emotional/Behavioral Problems
		Diabetes			Arthritis			Learning Disabilities
		AIDS or HIV			Seizures			Growth Problems

Are you interested in: (Please check all that apply)

Information Treatment Now Clarification of previous or confliction information

Are you aware that growth may have a strong influence on the success of orthodontic treatment?

Yes No