PATIENT INFORMATION

WELCOME TO OUR OFFICE!

Date _____ Gender M F Date of Birth _____ Age _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Primary Phone # _____ Social Security # _____

How would you like to receive appointment reminders? ☐ Email Email address _____
☐ Text Mobile # _____

Patient's Family Dentist _____

How did you hear about our practice: _____

Names of any relatives treated here _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ Email _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Spouse's Employer _____ Occupation _____ Email _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Subscriber ID # _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue:

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Subscriber ID # _____

Insurance Co. Address _____

Insured's Employer _____

SIGNATURE ON FILE

Signature (Parent's signature, if minor) _____ Date _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____

I understand that where appropriate, credit bureau reports may be obtained.

OFFICE USE ONLY

Office: _____

DENTAL HISTORY

HAVE YOU EVER HAD THE FOLLOWING TREATMENT:	YES	NO
Orthodontic (straightening of the teeth) As a child _____, or an adult _____.		
Extractions How long ago_____ Reason for extractions _____		
Periodontal treatment		
Mouthguard or splint (plastic device between your teeth)		
Treatment or surgery to change your bite		

ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

Sores, lumps or irritated areas in your mouth		
Food catching or collecting between your teeth		
Clenching or grinding your teeth		
Clicking, popping or grating noise in your jaw when chewing Does it bother you? _____		
Numbness or tingling in your mouth or face		
Would you change anything about your teeth or smile?		

Over the past five years, how often have you been seen for teeth cleaning? _____

The date of your last visit to a dentist _____.

That dentist's name _____

DATE: _____ PATIENT SIGNATURE _____

Patient Name _____ Record No. _____

Date of Birth ____/____/____

MEDICAL HISTORY

Physician _____
Address _____
Phone No. _____

1. When was your last physical exam? _____
2. Have there been any changes in your general health with the past year? _____
3. Is a physician for any reason treating you at present? _____
4. What medicine(s) are you taking now? _____
5. Have you ever been hospitalized for any illness, accident or surgery? _____
   If yes, when and why? _____
6. Woman: Are you pregnant now? _____

Do you have or have you had any of the following:

	Yes	No
7. Heart Trouble (including heart murmurs, valve, prosthesis/pacemaker)		
8. Rheumatic fever		
9. High/Low blood pressure		
10. Kidney problems		
11. Liver Disease (hepatitis)		
12. Jaundice		
13. Diabetes		
14. Anemia, Sickle cell, Iron		
15. Prolonged bleeding		
16. Severe infections		
17. Epilepsy		
18. Fainting		
19. Convulsions		
20. Pneumonia		
21. Tuberculosis		
22. Venereal Disease, AIDS, ARC		
23. Latex or vinyl (glove) allergy		
24. Metal Allergies (jewelry, etc.)		
25. Arthritis		
26. Allergy, hay fever, hives		
27. Asthma		
28. Sinus problems		

Are you allergic to or have you had any unusual reactions to the following?

	Yes	No	Unknown
29. Penicillin			
30. Dental local			
31. Barbiturates			
32. Codeine or other narcotics			
33. Aspirin			
34. Sedatives			
35. Sulfa			

36. Specify other _____

Do you have any other disease, condition emotional problems you would like to bring to our attention?

PRIVACY NOTICE

Patient name_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____

Patient or Responsible Party Date