

Patient:

Nickname: _____ Email Address: _____
Address: _____ Telephone (Home/Work): _____
How would you like to be contacted for appointment reminders? TEXT EMAIL
Cell phone number: _____ Cell phone carrier: _____
Birthdate: _____ Age: _____ Sex: _____ Race: _____
School/Employer _____ Grade/Position: _____
Interests/Arts/Music/Sports _____
Other family members treated here: _____
Dentist's name: _____ Last Visited: _____

Responsible Party

Parent/Guardian Name (if not self): _____ Telephone (Home/Work): _____
Relationship to Patient: _____
How would you like to be contacted for appointment reminders? TEXT EMAIL
Cell phone number: _____ Cell phone carrier: _____
E-mail: _____
Address: _____
Date of Birth: _____ Employer: _____
Parent/Guardian Name (if not self): _____ Telephone (Home/Work): _____
Relationship to Patient: _____
How would you like to be contacted for appointment reminders? TEXT EMAIL
Cell phone number: _____ Cell phone carrier: _____
E-mail: _____
Address: _____
Date of Birth: _____ Employer: _____

Health History

Abnormal bleeding	___	Bulimia	___	Downs Syndrome	___	Hepatitis	___	Muscular disorders	___	Rheumatic Fever	___
ADD/ADHD	___	Cancer	___	Drug allergies	___	High Blood pressure	___	Nervous Disorders	___	Scoliosis	___
Allergies	___	Cerebral palsy	___	Emotional disorders	___	HIV/AIDS	___	Organ Transplant	___	Seizures	___
Anemia	___	Chest pains	___	Epilepsy	___	Kidney problems	___	Painful chewing	___	Speech problem	___
Arthritis	___	Chronic neck pain	___	Fainting, Dizziness	___	Latex allergies	___	Periodontal problem	___	TMJ problems	___
Aspirin	___	Cold Sores/ Herpes	___	Glaucoma	___	Low Blood Pressure	___	Pneumonia	___	Tooth Grinding	___
Asthma	___	Diabetes	___	Headaches	___	Metal allergies	___	Pregnant	___	Tuberculosis	___
Autoimmune	___		___	Heart condition	___	Mouth breathing	___	Plastic Allergies	___	Operations or Hospitalizations	___

Any disease, problems, or allergies not mentioned above?

Allergies to any medications, metals, latex, vinyl, acrylic, foods?

Current medications, nutrient supplements, herbal medications, or non-prescription medication?

Dental History

Any face, mouth or teeth injuries?

Do gums bleed when brushed or flossed?	Y	N
Does the patient normally breathe through the mouth while awake or sleep?	Y	N
Does your child have any habits that we should be aware of? (thumb sucking, lip biting, tongue thrust)	Y	N
Are you presently in any dental pain?	Y	N
Do your teeth or jaws ever feel uncomfortable when you awake in the morning?	Y	N
Are you aware of your jaw clicking or popping?	Y	N
Are you aware of clenching your teeth during the day?	Y	N
Have you ever been told that you grind your teeth?	Y	N
Female Patients only:		
Are you pregnant?	Y	N
Has menstruation started?	Y	N
Aware or concerned about under or over developed jaw?	Y	N
Any relative with similar tooth or jaw relationships?	Y	N
Have you had previous orthodontic treatment?	Y	N
How often does your child brush per day? _____ Floss? _____		

What is your primary concern? Why are you here?

Do you feel that your concerns are more related to: _Cosmetics _____Prevention _____Function
Any other questions?

Financial/Insurance Information

Name of Primary Dental Insurance: _____ Telephone: _____
Name of Policy Holder: _____ Relationship to patient: _____
Insurance ID number: _____ Address: _____
Group # _____
Policy Holders Birthdate: _____ Social Security: _____

Name of Secondary Dental Insurance: _____ Telephone: _____
Name of Policy Holder: _____ Relationship to patient: _____
Insurance ID number: _____ Address: _____
Group # _____
Policy Holders Birthdate: _____ Social Security: _____

Whom may we thank for referring you to us? How did you hear about us? _____

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any future changes.

Signature: _____ Relationship To Patient: _____ Date: _____



PRIVACY NOTICE

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;
- 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

Date