PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: _____
(LAST) (FIRST) (MIDDLE INITIAL)

Address: _____
(STREET) (APT#) (CITY,ST,ZIP)

Birthdate: _____ SS #: _____ Occupation: _____

Employer: _____

Work #: _____ Home #: _____ Cell #: _____

E-mail Address: _____

Hobbies/Sports: _____

School: _____

Other family members seen by us (provide age): _____

Whom may we THANK for referring you to our office?: _____

Dentist's Name: _____ City: _____ Ph #: _____ Last Visit Date: _____

Responsible Party's Signature: _____ Today's Date: _____

INSURANCE INFORMATION

INSURANCE: Insurance information must be filled out completely before you come in for your initial appointment in order to accurately determine your orthodontic benefits and subsequently bill your insurance. (Note: Orthodontics is Dental and TMJ is Medical)

Do you have Orthodontic Insurance? ☐ No ☐ Yes Provider: _____ ID #: _____

Insurance Address: _____ Ph # : _____

Name of Subscriber: _____ Subscriber Birthdate: _____ Subscriber SS #: _____

Secondary Insurance? ☐ No ☐ Yes Provider : _____ ID #: _____

Insurance Address: _____ Ph # : _____

Secondary Subscriber: _____ Subscriber Birthdate: _____ Subscriber SS #: _____

RESPONSIBLE PARTY INFORMATION

Note: If separated/divorced the responsible party of the child is the custodial parent. The person responsible for account and signing contract is the only person legally able to acquire any information regarding patient. If responsible party has legal custody of a person under 18 and the relationship to the person is not mother/father, please provide information below

Name: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____

Cell #: _____ Work #: _____ SS #: _____ Birthdate: _____

Address (if different from above): _____
(STREET) (APT#) (CITY,ST,ZIP)

Mother's Information: ☐ Step Mother ☐ Guardian Name: _____ Birthdate: _____

Father's Information: ☐ Step Father ☐ Guardian Name: _____ Birthdate: _____

Who is Responsible for Making Appointments? Name: _____

Relationship to Patient: _____ Cell #: _____

If you are NOT the Patient or the <u>Responsible Party</u> filling out this form, please provide:

Name: _____ Relationship to Patient: _____

Address: _____ Ph #: _____
(STREET) (APT#) (CITY,ST,ZIP)

Signature: _____ Today's Date: _____

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I understand that credit bureau information may be obtained.

First impression ORTHODONTICS

ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

Date: _____

Name: _____

I. SUBJECTIVE COMPLAINTS AND CONCERS

A. What are the patient's or parents' main concerns regarding the jaw and teeth?

	Mild	Moderate	Severe
1. Chronic Neck Pain	☐	☐	☐
2. Facial Pain	☐	☐	☐
3. Gum Recession	☐	☐	☐
4. Gum Problems	☐	☐	☐
5. Headaches	☐	☐	☐
6. Jaw Dysfunction	☐	☐	☐
7. Jaw Pain	☐	☐	☐

Check all that apply:

- ☐ "Buck" Teeth / Overjet
- ☐ Crowding of Upper Teeth
- ☐ Crowding of Lower Teeth
- ☐ Crowding of Upper Teeth & Lower Teeth
- ☐ Crossbite
- ☐ Grinding Teeth
- ☐ Gummy Smile
- ☐ Impacted Tooth / Teeth
- ☐ Improper Tooth Position
- ☐ Irregular Facial Proportions
- ☐ Irregular Shaped Tooth / Teeth
- ☐ Missing Tooth / Teeth
- ☐ Mouth Too Small
- ☐ Open Bite
- ☐ Overbite
- ☐ Prominent Lower Jaw (too "strong")
- ☐ Protrusion of Teeth
- ☐ Recessive Lower Jaw (too "weak")
- ☐ Rotations
- ☐ Small Teeth
- ☐ Spaces
- ☐ Underbite
- ☐ Other: _____

B. Family members with similar concerns:

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Other: _____

II. MEDICAL DENTAL HISTORY

A. Has menstruation started? ……. ☐ **No** ☐ **Yes**

B. Has the patient ever had any of the following conditions?

- ☐ Allergies
- ☐ AIDS / ARC / HIV (Circle)
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Disease
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hearing Disorders
- ☐ Heart Disease / Surgery
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure / Low Blood Pressure (Circle)
- ☐ Hospitalized for Any Reason
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Ringing of Ears
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Trauma (to face, teeth, jaws, or head)*
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____
- ☐ _____

_____

* If yes, please explain: _____

_____

_____

C. Medication:

- ☐ Antibiotics
- ☐ Birth Control Pills
- ☐ Bone Treatment (Fosamax, Bisphosphonate, etc.)
- ☐ Diet Pills (Diuretics)
- ☐ Heart Pills (Digtails, etc.)
- ☐ Insulin
- ☐ Muscle Relaxants (Flexeril, etc.)
- ☐ Pain Pills (Demerol, Codeine, etc.)
- ☐ Sleeping Pills
- ☐ Tranquilizers (Elvail, Valium, etc.)
- ☐ Vitamins
- ☐ Other: _____

D. Allergies to Medications / Food (The patient demonstrates an allergic response to)**:**

- ☐ Antibiotics (specifically): _____
- ☐ Aspirin
- ☐ Dairy Products
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Food Dyes
- ☐ Gluten
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Nuts
- ☐ Pain Pills (specifically): _____
- ☐ Other: _____

E. Airway and breathing:

		No	Yes
1.	Mouth breathing while awake or asleep	☐	☐
2.	Problem sleeping through the night	☐	☐
3.	Sleepiness or tire easily ……	☐	☐
4.	Problem focusing …….	☐	☐
5.	Frequent headaches ……..	☐	☐
6.	Snoring ……	☐	☐

F. Any History of the following:

		No	Yes
1.	Clenching	☐	☐
2.	Dental Anxiety	☐	☐
3.	Difficulty Chewing	☐	☐
4.	Finger Sucking	☐	☐
5.	Grinding	☐	☐
6.	Lip Biting	☐	☐
7.	Smoking.....	☐	☐
8.	Sore Teeth.....	☐	☐
9.	Speech Problems	☐	☐
10.	Tongue Thrusting	☐	☐

G. Regular dental checkups:

- ☐ More than twice a year
- ☐ Twice a year
- ☐ Once a year
- ☐ Only if necessary
- ☐ Never

III. ORTHODONTIC HISTORY

A. Patient's interest in orthodontic treatment:

- ☐ Dentist recommended
- ☐ Cosmetic only
- ☐ Function and health

B. Has the patient ever had previous orthodontic treatment?..... ☐ No ☐ Yes

IV. OTHER INFORMATION

A. Has the patient ever had any unusual dental experiences?
☐ No ☐ Yes If yes, please explain: _____

_____

_____

Comments: _____

_____

_____

To the best of my knowledge, all the preceding answers are true and correct.

_____
Patient/Responsible Party's Signature Date

_____
Orthodontist's Signature Date

PRIVACY HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and request a copy of your Notice of Privacy practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I Understand that you reserve the right to obtain the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care Operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date, the revoke of this consent is not affected.

Print Patient Name: _____

Signature of Patient/Parent/Guardian: _____

Date: _____

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