NEW Adult Patient Information

Patient Information

Patient's Name: _____
last first middle likes to be called

Date of Birth: _____ Age: _____ Sex: _____ E-Mail: _____

Phone: _____ Cell Phone/Alternate Phone: _____

Home Address: _____
street city state zip

Marital Status: ○ single ○ married ○ separated ○ divorced ○ remarried ○ widowed

Patient's Dentist: _____ Referred By: _____ Physician: _____

Names & Ages of Children: _____

_____

Occupation: _____ Work Phone: _____

Employed By: _____

Spouse's Name: _____ Work Phone: _____

Occupation: _____ Employed By: _____

Dental Insurance Information

Person Responsible for Account _____
last first middle

Relationship to Patient: _____ Birth date: _____ Soc. Sec. #: _____

Address (if different from patient) _____
street city state zip

Phone: _____ Cell Phone/Alternate Phone: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____
street city state zip

Dental Insurance Company: _____

Dental Insurance Company Address: _____

Contact #: _____ Group #: _____ Subscriber #: _____

Name of Other Dependents Under This Plan: _____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

Now or in the past, have you had:

yes no dk/u (don't know/understand)

- O O O Birth defects or hereditary problems?
- O O O Bone fractures, any major accidents?
- O O O Rheumatoid or arthritic conditions?
- O O O Endocrine or thyroid problems?
- O O O Kidney problems?
- O O O Diabetes?
- O O O Cancer, tumor, radiation treatment or chemotherapy?
- O O O Stomach ulcer or hyperacidity?
- O O O Polio, mononucleosis, tuberculosis, pneumonia?
- O O O Problems of the immune system?
- O O O AIDS or HIV positive?
- O O O Hepatitis, jaundice or liver problem?
- O O O Fainting spells, seizures, epilepsy or neurological problem?
- O O O Mental health disturbance or depression?
- O O O Vision, hearing, tasting or speech difficulties?
- O O O Loss of weight recently, poor appetite?
- O O O History of eating disorder (anorexia, bulimia)?
- O O O Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- O O O High or low blood pressure?
- O O O Tired easily?
- O O O Chest pain, shortness of breath or swelling ankles?
- O O O Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- O O O Skin disorder?
- O O O Do you have a well-balanced diet?
- O O O Frequent headaches, colds or sore throats?
- O O O Eye, ear, nose or throat condition?
- O O O Hayfever, asthma, sinus trouble or hives?
- O O O Tonsil or adenoid conditions?
- O O O Osteoporosis?

Allergies or reactions to any of the following:

- O O O Local anesthetics (Novocaine or Lidocaine)
- O O O Aspirin
- O O O Ibuprofen (Motrin, Advil)
- O O O Penicillin or other antibiotics
- O O O Sulfa drugs
- O O O Codeine or other narcotics
- O O O Metals (jewelry, clothing snaps)
- O O O Latex (gloves, balloons)
- O O O Vinyl
- O O O Acrylic
- O O O Animals
- O O O Foods (specify) _____
- O O O Other substances (specify) _____

yes no dk/u (don't know/understand)

- O O O Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

yes no dk/u (don't know/understand)

- O O O Do you currently have or ever had a substance abuse problem?
- O O O Do you chew or smoke tobacco?
- O O O Operations? Describe: _____
- O O O Hospitalized? For: _____
- O O O Other physical problems or symptoms? Describe:
- O O O Being treated by another health care professional? For: _____ Date of most recent physical exam? _____
- O O O Do you have any other medical conditions that we should know about?

Women Only:

- O O O Are you pregnant?
- O O O Are you anticipating becoming pregnant?

Family Medical History:

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain.

- O Bleeding disorders O Diabetes O Arthritis
- O Severe allergies O Unusual dental problems
- O Jaw size imbalance

Any other family medical conditions that we should know about? _____

Dental History

Now or in the past, has the patient had:

yes no dk/u (don't know/understand)

- O O O Permanent or "extra" (supernumerary) teeth removed?
- O O O Supernumerary (extra) or congenitally missing teeth?
- O O O Chipped or otherwise injured primary (baby) or permanent teeth?
- O O O Teeth sensitive to hot or cold; teeth throb or ache?
- O O O Jaw fractures, cysts or mouth infections?
- O O O "Dead teeth" or root canals treated?
- O O O Bleeding gums, bad taste or mouth odor?
- O O O Periodontal "gum problems"?
- O O O Food impaction between teeth?
- O O O "Gum boils", frequent canker sores or cold sores?
- O O O Thumb, finger, or sucking habit? Until what age? ___
- O O O Abnormal swallowing habit (tongue thrusting)?
- O O O History of speech problems?
- O O O Mouth breathing habit, snoring or difficulty in breathing?
- O O O Tooth grinding or jaw clenching?
- O O O Any pain, clicking or locking in jaw or ringing in the ears?
- O O O Any pain or soreness in the muscles of the face or around the ears?

yes no dk/u (don't know/understand)

- O O O Difficulty in chewing or jaw opening?
- O O O Have you ever been treated for "TMD" or "TMJ" problems?
- O O O Aware of loose, broken or missing restorations (fillings)?
- O O O Any teeth irritating cheek, lip, tongue or palate?
- O O O Concerned about spaced, crooked or protruding teeth?
- O O O Aware or concerned about under or over developed jaw?
- O O O Any relative with similar tooth or jaw relationships?
- O O O Any wisdom tooth problems?
- O O O Had periodontal (gum) treatment?
- O O O Had any serious trouble associated with any previous dental treatment?
- O O O Been under another dentist's care?
  Specialist _____
  Other _____
- O O O Ever had a prior orthodontic examination or treatment?
- O O O Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ floss: _____

What is your primary concern? _____

Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Patient)

There are two different types of x-ray images (radiographs) that can be taken of patients at Ortho360 to assist in the diagnosis and recommended treatment. These include the panoramic and cephalometric orthodontic extraoral x-ray images. Since we can see only about one-third of the actual tooth, radiographs provide valuable information that our doctors cannot visualize otherwise. Radiographs are the only way to reliably view the bone, roots, attachments, interproximal areas, and under and around restorations. Radiographs also provide a starting point for what conditions exist at the beginning of treatment, and what changes may occur by the patient's next appointment. Detection of harmful conditions as well as the overall progress being made during the orthodontic treatment are often impossible without radiographs.

I understand that x-rays (radiographs) are necessary to provide appropriate diagnosis and treatment for myself.

I have read and understand all of the new patient form questions and statements. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to the history record or medical/dental status, I will so inform this practice.

Patient Signature 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 payers' 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 Signature Date

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

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 in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.
You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____
Patient's Signature

_____
Print Name

_____
Date