Adult New 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

Referred by: _____

Names & Ages of Children: _____

_____

Occupation: _____ Work Phone: _____

Employed By: _____

Spouse's Name: _____ Work Phone: _____

Occupation: _____ Employed By: _____

X-Ray Consent

Ortho 360 utilizes two different types of x-ray/radiograph images to assist in the diagnosis and recommended treatment of patients. These include the panoramic and cephalometric orthodontic extraoral x-ray images. Since only about one-third of the actual tooth is visible in the mouth, radiographs provide valuable information doctors cannot otherwise see. Radiographs provide the only way to view the bone, roots, attachments and interproximal areas as well as under and around restorations. Radiographs also provide a starting point for what current conditions a patient has at the start of treatment and what changes may occur by the patients next appointment. Detection of harmful conditions as well as the overall progress being made during treatment are often impossible without radiographs.

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

Signature of Patient: _____ Date: _____

Medical/Dental History

Physician's Name:_____
Phone #:_____
Dentist's Name:_____ Phone #:_____
Date of last visit:_____

[ ]Yes [ ]No Are you currently under any medical treatment? _____
[ ]Yes [ ]No Do you have pain, clicking and/or popping noises in your jaw?_____
[ ]Yes [ ]No Are you aware of of either clenching or grinding of teeth? _____
[ ]Yes [ ]No Do you have frequent headaches? How often? _____
[ ]Yes [ ]No Do you have ear problems? (Aches, ringing, dizziness, fullness)_____
[ ]Yes [ ]No Do you have difficulty breathing through your nose? _____
[ ]Yes [ ]No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?_____
[ ]Yes [ ]No Do you have speech problems, or are you in speech therapy? _____
[ ]Yes [ ]No Have you had your tonsils and/or adenoids removed? _____
[ ]Yes [ ]No Has there been any history of: [ ]Joint swelling [ ]Asthma [ ]TB [ ]AIDS [ ]Kidney [ ]Liver Condition [ ]Epilepsy [ ]Rheumatic Fever [ ]Other major illness?_____
[ ]Yes [ ]No Do you bleed easily? _____
[ ]Yes [ ]No Is there a tendency to faint or become dizzy?_____
[ ]Yes [ ]No Do you have allergies? Sulphur, penicillin, novocaine, latex, metal, etc?_____
[ ]Yes [ ]No Are you currently taking any medications? List:_____
[ ]Yes [ ]No Do you have a heart condition? [ ]Yes [ ]No Do you premedicate? [ ]Yes [ ]No Cardiologist_____
[ ]Yes [ ]No Do you have sleep apnea? _____
[ ]Yes [ ]No Do you smoke or chew tobacco? _____
[ ]Yes [ ]No Have there been any injuries to your teeth?_____
[ ]Yes [ ]No Have you had any permanent teeth extracted? _____
[ ]Yes [ ]No Have we treated any other family members? _____
[ ]Yes [ ]No Have you had orthodontic treatment before? When:_____

Anything additional you would like for us to know?:

_____
_____
_____

Signature: _____
Date:_____

I have read and understand all of the new patient form questions and statements. I will not hold my orthodontist, or any of their staff members responsible for any errors or omissions I have made in the completion of this form. If there are any changes to my medical history or dental status I understand it is my responsibility to relay that information to Ortho 360 at that time.

Agreed: _____ Date:_____
Signature of Patient

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 Date

_____

Print Name

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