TRI-CITY ORTHODONTICS

Patient (Adult) Information

Patient Name_____ _____ _____ _____
LAST FIRST MIDDLE PREFERRED NAME

☐ Male ☐ Female Date of Birth_____ Social Security #_____

Address_____ _____ ____ _____
STREET CITY STATE ZIP

Home Phone_____ Cell Phone_____ Work Phone_____

Best Contact Phone # : ☐ Home ☐ Cell ☐ Work

Employer_____ Occupation_____

Dentist_____ Date last seen? _____

Is any dental work pending? ☐ No ☐ Yes… Please describe_____

Whom may we thank for referring you to our office? _____

Children Information:

Name_____ DOB_____ Name_____ DOB_____

Name_____ DOB_____ Name_____ DOB_____

Dental Insurance (please furnish insurance card)

Insurance Co._____ **ID#**_____ Group#_____

Subscriber Name _____ DOB _____ Relationship_____

Employer_____ Occupation_____

Do you have dual coverage? ☐ No ☐ Yes If Yes, please complete the following:

Insurance Co._____ **ID#**_____ Group#_____

Subscriber Name _____ DOB _____ Relationship_____

Employer_____ Occupation_____

Reminder Contact Information

How would you like us to remind you of future appointments? **Phone Call** ☐ **Text** ☐ **Email** ☐

Cell #_____ Cell Ph Company_____

Email _____

INFORMATION RELEASE: I authorize the release of any information requested by my insurance company regarding my treatment.
NOTE: This office will not release information regarding your care, or furnish copies of your records to anyone without your signed permission.

Patient Signature _____ Date _____

Please complete the following health questionnaire as fully and completely as possible. Also write in any information that you feel might be helpful

PATIENT……

WHAT ARE YOUR MAIN CONCERNS REGARDING YOUR TEETH AND JAWS?
……. Crowding
……. Overbite
……. Buck teeth
……. Misalignment
……. Receded jaw
……. Prominent jaw
……. Gummy smile
……. Spacing
……. Gum disease
……. Missing teeth
……. Jaw dysfunction
……. Mouth too small
……. Clicking jaw joint
……. Irregularly shaped teeth
……. Protrusion of teeth
……. Ringing in ears
……. Headaches/facial pain
……. Neck pain
……. Jaw pain
……. Irregular facial proportions
……. Cross bite
……. Under bite
……. Open bite
……. Dentist recommended
……. Second opinion
Other……

YOUR CURRENT PHYSICAL HEALTH?
……. Excellent ……. Good
……. Fair ……. Poor

YOUR CURRENT MENTAL HEALTH?
……. Excellent ……. Good
……. Fair ……. Poor

PLEASE LIST ALL YOUR CURRENT MEDICATIONS:
……. Heart pills (digitalis, etc.).....
……. Antibiotics.....
……. Pain pills.....
……. Birth Control Pills.....
……. Muscle relaxants.....
……. Anti-Anxiety/Anti-Depressants……
.....
…… Bisphosphonates.....
…… Other.....
……
……

HOW OFTEN DO YOU HAVE DENTAL CHECKUPS?
……. Once per year
……. Twice per year
……. More than twice per year
……. Only if urgent (emergency only)
……. Never

HAVE YOU EVER HAD, OR NOW HAVE ANY OF THE FOLLOWING CONDTIONS?
……. Allergies:
……. Seasonal
……. Penicillin
……. Latex
……. Metal/Nickel
……. Other……
……. Anemia
……. Blood disease
……. Prolonged bleeding
……. Hepatitis
……. AIDS or HIV positive
……. Rheumatic fever
……. Cancer or tumor
……. Heart disease or murmur
……. Tuberculosis
……. Diabetes
……. Endocrine problems
……. Bone disorders
……. Seizures/Epilepsy
……. Tonsillitis
……. Mononucleosis
……. Tonsils removed
……. Adenoids removed
……. Asthma
……. Autoimmune
……. High blood pressure
……. Sleep disturbance
……. Eating disorder
……. Mouth breathing
……. Loud snoring
……. Severe head or facial injury
……. Thumb/finger sucking habit
……. Previous …… Current
……. Bites nails
……. Plays musical wind instrument
……. Previous TMJ treatment
……. Previous orthodontic treatment
……. Family history orthognathic surgery
……. Repaired cleft lip/palate
……. Osteoporosis
……. Emotional stress

DOE YOU HAVE DIFFICULTY CHEWING?
……. No
……. Yes
……. Teeth don't meet well
……. Pain when chewing
……. Other.....

DO YOU HAVE PAIN/CLICKING IN THE JAW JOINT?
……. No
……. Yes
….. Right
….. Left

DO YOU GRIND/CLENCH YOUR TEETH?
……. No
……. Yes
……. Uncertain

HAVE YOU EVER BEEN TOLD YOU HAVE A TONGUE THRUST SWALLOWING PATTERN?
……. No
……. Yes
……. Uncertain

HAVE YOU HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?
……. No
……. Yes, WHEN.....

NEED OF PRE-MEDICATION ANTIBIOTIC DUE TO HEART CONDITION/JOINT REPLACEMENT?
……. No
……. Yes, ……

DO YOU USE TOBACCO PRODUCTS?
……. No
……. Yes, ...

ARE THERE ANY MEDICAL, DENTAL, OR SURGICAL PROBLEMS WHICH HAVE NOT BEEN COVERED ON THIS FORM?
……. No
……. Yes ……
……..
……..

Signature

Date

ADDITIONAL INFORMATION:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name_____ **DOB**_____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can be used to, but are not excluded to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____ **Date**_____

Printed Name _____

Relationship to Patient: ☐ **Self** ☐ **Parent/Guardian** ☐ **Power of Attorney**

☐ I give my permission for you to discuss medical and/or financial information with:

Name:_____ Relationship to Patient_____
Name:_____ Relationship to Patient_____
Name:_____ Relationship to Patient_____
Name:_____ Relationship to Patient_____

……..

For Office Use Only:

We were unable to obtain the patient's written acknowledgement for our Notice of Privacy Practices Acknowledgement due to the following reasons:

- o Patient/Guardian refused to sign.
- o Communication barriers.
- o Emergency situation.
- o Other

Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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 and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775