



Patient Information

Patient Name _____
LAST FIRST MIDDLE PREFERRED NAME

Male Female Date of Birth _____ Age _____ Best Contact Ph # _____

Physical Address _____
STREET CITY STATE ZIP

Dentist _____ Date last seen? _____

Is any dental work pending? No Yes... Please describe _____

Whom may we thank for referring you? _____

Sibling Information:

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

Parent/Guardian

Name _____ Relationship _____ SS # _____ DOB _____

Address _____ Home # _____ Cell _____ Work _____

Employer _____ Occupation _____

Name _____ Relationship _____ SS # _____ DOB _____

Address _____ Home # _____ Cell _____ Work _____

Employer _____ Occupation _____

Dental Insurance (please furnish insurance card)

Insurance Co. _____ ID# _____ Group# _____

Subscriber Name _____ DOB _____ Relationship _____

Employer _____ Occupation _____

Do you have secondary 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 # 1) _____ Name _____ Cell Ph Company _____

Cell # 2) _____ Name _____ Cell Ph Company _____

Email 1) _____ 2) _____

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.

Parent/Guardian/Guarantor 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 THE PATIENT'S OR PARENT'S MAIN CONCERNS REGARDING THE 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.....

PATIENT'S CURRENT PHYSICAL HEALTH?

- Excellent Good
- Fair Poor

PATIENT'S CURRENT MENTAL HEALTH?

- Excellent Good
- Fair Poor

PLEASE LIST ALL CURRENT MEDICATIONS TAKEN BY PATIENT:

- Heart pills (digitalis, etc.).....
- Antibiotics.....
- Pain pills.....
- Birth Control Pills.....
- Muscle relaxants.....
- Anti-Anxiety/Anti-Depressants.....
- Bisphosphonates.....
- Other.....

HOW OFTEN DOES THE PATIENT HAVE DENTAL CHECKUPS?

- Once per year
- Twice per year
- More than twice per year
- Only if urgent (emergency only)
- Never

HAS THE PATIENT EVER HAD, OR NOW HAVE ANY OF THE FOLLOWING CONDITONS?

- 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
- Pre-medication antibiotic
- 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

HAS PATIENT REACHED PUBERTY?

- No
- Yes (APPROX DATE

DOES THE PATIENT HAVE DIFFICULTY CHEWING?

- No
- Yes
 - Teeth don't meet well
 - Pain when chewing
 - Other.....

DOES THE PATIENT HAVE PAIN/CLICKING IN THE JAW JOINT?

- No
- Yes
 - Right
 - Left

DOES THE PATIENT GRIND/CLENCH THE TEETH?

- No
- Yes
- Uncertain

HAS THE PATIENT EVER BEEN TOLD THEY HAVE A TONGUE THRUST SWALLOWING PATTERN?

- No
- Yes
- Uncertain

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?

- No
- Yes (WHEN

WHAT IS THE PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

- Wants treatment
- Treatment only if necessary
- Unwilling, but will cooperate if treatment is needed
- Uncooperative

ARE THERE ANY MEDICAL, DENTAL, OR SURGICAL INFORMATION WE HAVE NOT MENTIONED THAT WE SHOULD KNOW ABOUT?

- No
- Yes

Signature of Person Filling Out Form

Printed Name

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 _____

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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