Welcome

Thank you for selecting our office for your orthodontic evaluation. Please help us by completing this orthodontic health questionnaire. If you have any questions or need assistance, please ask us ~ We will be happy to help you.

Patient Information *(CONFIDENTIAL)*

Date ____________________________

Patient's Name ____
Last First Middle Initial Nickname

Age ________________ Date of Birth ____________________________________ Sex ___________

Address ____

City ____________________________________ State __________________________ Zip ____________________

Home Phone ___________________ Cell _____________________ E-mail _________________________________

Employer _______________________ Work Phone _____________________ Social Security # _______________

Spouse ______________________________ Work Phone ____________________ Cell ______________________

Marital Status ❒ Married ❒ Separated ❒ Divorced ❒ Single

Whom may we thank for recommending our office to you?

❒ Self ❒ Dentist ❒ Others ______________________________

Responsible Party

❒ Self ❒ Other ~ If other than self, please complete the following:

Name of Responsible Party _________________________ Home Phone _________________ Cell _______________

Address _____________________________________ City ____________________ State ________ Zip __________

Employer ____ Work Phone ________________________________

E-mail ____ Social Security # ____________________________

Insurance Information

If you have orthodontic insurance, please complete the following (the person's information the insurance is under):

Name of the Insured ______________________________ S.S. # _______________________ Date of Birth _________

Name of Insurance Company ___________________________________ Group # ____________________________

Ins. Co. Address ___________________________________ City __________________ State ________ Zip _______

Ins. Co. Phone No. __________________________________

Concerns

When did you first realize that you might have a problem requiring orthodontic treatment?

____

What concerns you most about your teeth or jaws? ____

Which of the following best describes your interest in orthodontic treatment?

❒ I want treatment ❒ I am willing if treatment is necessary ❒ I am not sure

Dental History

Dentist_______________________________________ Date of last dental examination ______________________

❒ Yes ❒ No Have there been any injuries to the face, mouth or teeth?

❒ Yes ❒ No Are you or have you been made aware of clenching or grinding your teeth?

❒ Yes ❒ No Do your jaw joints make clicking, popping or grating sounds?

❒ Yes ❒ No Do you have chronic headaches or neck and shoulder pain?

❒ Yes ❒ No Do you have now or have you ever had pain in your jaw joints or in the side of your face or around your ears?

❒ Yes ❒ No Do you have missing teeth?

❒ Yes ❒ No Do you have extensive bridges or crowns?

❒ Yes ❒ No Have you ever had gum disease?

❒ Yes ❒ No Have you or any member of your family had orthodontic treatment?
If yes, please explain ____

❒ Yes ❒ No Have you worn a splint before?

How often do you brush your teeth?
❒ Several times a day ❒ Once a day ❒ Occasionally

Medical History

Physician ____

Do you have any history of major illness? ❒ No ❒ Yes

If yes, please explain ____

Are you currently under the care of a physician for any medical conditions? ❒ No ❒ Yes

If yes, please explain ____

Place a check beside the medical conditions which the patient has now or had previously:

❒ Anemia	❒ Cancer	❒ Glaucoma	❒ Kidney disease	❒ Thyroid
❒ Arthritis	❒ Cerebral Palsy	❒ Hearing Problems	❒ Lung disorders	❒ Tuberculosis
❒ Asthma	❒ Cold sores/oral ulcers	❒ Heart disorders	❒ Nervous disorders	❒ Joint Replacement
❒ AIDS/HIV	❒ Diabetes	❒ Heart murmur	❒ Pneumonia	❒ Other
❒ Bleeding disorders	❒ Endocrine disorders	❒ Hepatitis	❒ Rheumatic Fever	
❒ Bone disorders	❒ Epilepsy	❒ High blood pressure	❒ Sleep Apnea	

Please comment on any checked above : ____

Do you smoke or chew tobacco? ❒ No ❒ Yes

Do you have any allergies or drug sensitivities? ❒ No ❒ Yes______________________________________

Do you have a nickel allergy? ❒ No ❒ Yes

Have you ever been told you needed antibiotics before having dental work performed? ❒ No ❒ Yes

Please list all medications you are presently taking: ____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and /or health practitioners. I agree to be responsible for payment of all services. I understand that when necessary credit information may be obtained.

*X*____
Signature

PATIENT HIPAA CONSENT FORM

(Acknowledgement of receipt of Notice of Privacy Practices and Consent for Use and Disclosure of Health Information)

I understand that, as part of my healthcare, this office originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and clinical information to my bill
- A means by which a third-party payer can verify that services were performed

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that this office reserves the right to change their notice and practices and will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.

Signed this __________ day of ____________________________, 20_____

Patient name (please print): ______________________________

Signature: ____

Relationship to Patient: ______________________________