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PATIENT INFORMATION

Date: ____________________

Patient's name: ____ ____________________
Last First Middle Nickname

Address: ____
Street City State Zip

Home Phone: ____________________ **Cell Phone:** _____________________ **Birthdate:** _____________ **Gender:** _____

Dentist Name: ______________________________________ **School Name/Employer:** _______________________________

Sports or Hobbies: ____ **No. of Brothers:** _______ **No. of Sisters:** _______

If patient is a minor, give parent's or guardian's name: ____

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

RESPONSIBLE PARTY INFORMATION

Name: ____ ____________________
Last First Middle Nickname

Address: ____
Street City State Zip

How long at this address?__________ **Previous Address (If less than 3 years):** _______________________________________

Home phone: ________________________ **Work phone:** ______________________ **Cell phone:** _______________________

Email address: ____ **Relationship to Patient:** _________________________

Social Security #: _____________________________ **Birthdate:** __________________ **Marital Status:** ________________

Employer: ____________________________________ **Occupation:** _____________________ **No. years employed:** ______

Spouse or Other Responsible Party: ____ ________________
Last First Middle Nickname

Address: ____
Street City State Zip

Home phone: ________________________ **Work phone:** ______________________ **Cell phone:** _______________________

Email address: ____ **Relationship to Patient:** _________________________

Social Security #: ____________________________ **Birthdate:** __________________ **Marital Status:** _________________

Employer: ______________________________________ **Occupation:** _____________________ **No. years employed:** ______

DENTAL INSURANCE INFORMATION

Policy Holder's Name: ____ **Insurance Company:** ______________________________

Birthdate: ____________________ **SS# or ID#:** __________________________________ **Group #:** _____________________________

Insurance Co. Address: ____ **Insurance Co. Phone:** ______________________

Do you have dual coverage? Yes____ No____ If yes: **Policy Holder's Name:** ______________________________________

Insurance Company: _________________________________ **Birthdate:** _______________ **SS# or ID#:** _________________________

Group #: ______________ **Insurance Address:** ____ **Phone #:** ______________________

MEDICAL HISTORY

Physician Name: ____ Date of Last Visit: _______________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? If Yes, Please List: ____

Yes No Is the patient allergic to any medication?

Yes No Does the patient have a history of a major illness?

Yes No Has the patient had any operations?

Yes No Has the patient ever been involved in a serious accident?

Yes No Allergy to Latex or Nickel?

Yes No Has the patient ever taken any bisphosphonates (i.e. Fosamax, Boniva, Skelid, Actonel, Zometa)?

Female Patients only:

Yes No Is the patient pregnant?

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Heart Murmur	Dizziness	Herpes	Prolonged Bleeding
Nervous Disorders	Epilepsy	High Blood Pressure	Radiation/Chemo
Asthma or Hayfever	HIV / Aids	Rheumatic Fever	Bone Disorders
Gastrointestinal Disorders	Tuberculosis	Heart Problems	Kidney problems
Congenital Heart Defect	Arthritis	Tumor or Cancer	Anemia

Are there any medical conditions we have not discussed that you feel we should be aware of?

____

____

DENTAL HISTORY

What concerns you most about your teeth? ____

Yes No Have you been informed of any missing or extra permanent teeth?

Yes No Have the patient's tonsils or adenoids been removed?

Yes No Has the patient ever lost or chipped any teeth?

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

Yes No Is the patient a mouth breather?

Yes No Is any part of the mouth sensitive to temperature or pressure? Where?

Yes No Does the patient's gums bleed while brushing?

Yes No Does the patient have any type of thumb or tongue habit (thumb sucking, tongue thrust, etc)?

Yes No Do you feel the patient can benefit from Orthodontic treatment?

Yes No Has the patient ever seen an orthodontist? If yes, when? _____________________________

Yes No Has anyone in your family received orthodontic treatment? How did they feel about the result? _________________

Yes No Do the patient's teeth or jaws ever feel uncomfortable in the morning?

Yes No Are you aware of any jaw clicking or popping?

Yes No Does the patient have frequent or severe headaches?

Yes No Are you aware of any teeth grinding or clenching?

Yes No Have you ever noticed any problems with speech?

EMERGENCY CONTACT INFORMATION

Name of nearest relative/friend not living with you: ____

Complete address: ____

Phone #: ______________________________ **Relationship to Patient:** _______________________________

What Would You Like Orthodontic Treatment to Accomplish? _______________________________________

____

____

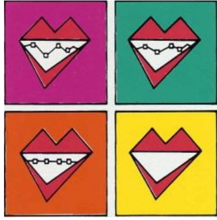
Benefits of Orthodontics:

Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health.

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Thomas Blase to perform a complete orthodontic evaluation.

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor): __________________________________ **Date:** ________________



HIPAA Patient Consent Form

By signing this form, you consent to our use and disclosure of protected health information for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. A copy of this Notice is available to you at your request in our office.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Consent was signed by: ____

Printed name of patient and/or Guardian

____

Signature of Patient/Guardian Relationship to Patient Date

Witness (Practice Representative): ____

Signature Date