Adult Health History

Today's Date: _____ I prefer to be called: _____

Name: _____

Birthdate: _____ Age: _____ ☐ Male ☐ Female SS#: _____

Email Address: _____

Home Address _____

Home #: _____ Cell #: _____

Employer: _____ Work #: _____

Employer's Address _____

How long there? _____ Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Current Dentist: _____

Person Responsible for Account: _____

Spouse Information

His / Her Name _____ Birthdate: _____

Cell #: _____ Work #:_____ SS#: _____

Employer: _____

Relative or Friend not living with you

His / Her Name: _____ Relation: _____

Cell # _____ Work #: _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis of any records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Primary Insurance Orthodontic Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Co. Phone #:_____ Group #: _____

Policy Owner Name: _____ Relationship to Patient: _____

Policy Owner's Birthday: _____ Policy Owners Employer: _____

Employer's Address: _____

Policy Owner's SSN: _____ ***Please Provide Copy of Insurance Card***

Secondary Insurance Orthodontic Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Co. Phone #:_____ Group #: _____

Policy Owner Name: _____ Relationship to Patient: _____

Policy Owner's Birthday: _____ Policy Owners Employer: _____

Employer's Address: _____

Policy Owner's SSN: _____ ***Please Provide Copy of Insurance Card***

Medical History

Do you have a current physician? Y N

Physician's Name: _____

Phone #: _____ Date of Last Visit: _____

Your current physical health his Good Fair Poor

Are you currently under the care of a physician? Y N
Please explain: _____

Do you smoke or use tobacco in any other forms? Y N

Have you had any metal rods, pins, or implants? Y N

Are you taking any medications? Y N

Please List: _____

For Women: Are you taking birth control? Y N

Are you pregnant? Y N Week #: _____

Are you nursing Y N

Are you allergic to any of the following?

Aspirin Y N Erythromycin Y N Penicillin Y N

Codeine Y N Jewelry/Metals Y N Tetracycline Y N

Dental Anesthetics Y N Latex Y N Other Y N

Please list any other allergies: _____

Have you had any of the following diseases/medical problems?

Abnormal Bleeding/Hemophilia	Y N	Herpes/Fever Blisters	Y N
AIDS	Y N	High Blood Pressure	Y N
Alcohol/Drug Abuse	Y N	HIV	Y N
Anemia	Y N	Hospitalized	Y N
Arthritis	Y N	Kidney Problems	Y N
Artificial Bones/Joints Valves	Y N	Liver Disease	Y N
Asthma	Y N	Low Blood Pressure	Y N
Blood Transfusion	Y N	Lupus	Y N
Cancer/Chemotherapy	Y N	Mitral Valve Prolapse	Y N
Colitis	Y N	Pacemaker	Y N
Congenital Heart Defect	Y N	Psychiatric Problems	Y N
Diabetes	Y N	Radiation Treatment	Y N
Difficulty Breathing	Y N	Rheumatic/Scarlett Fever	Y N
Emphysema	Y N	Seizures	Y N
Epilepsy	Y N	Shingles	Y N
Fainting Spells	Y N	Sickle Cell	Y N
Frequent Headaches	Y N	Sinus Problems	Y N
Glaucoma	Y N	Stroke	Y N
Hay Fever	Y N	Thyroid Problems	Y N
Heart Attack/Surgery	Y N	Tuberculosis (TB)	Y N
Heart Murmur	Y N	Ulcers	Y N
Hepatitis	Y N	Venereal Disease	Y N

Please list any serious medical condition(s) that you ever had:

_____

_____

_____

Medical History cont.

Have you been told (or noticed on your own) that you snore most nights? Yes No Unsure

Have you been told (or noticed on your own) that you stop breathing or struggle to breath in your sleep, sometimes followed by a gasp? Yes No Unsure

Are you tired, fatigued or sleepy most days? Yes No Unsure

Do you have acid indigestion or high blood pressure (or use medication to control either of these? Yes No Unsure

Are you overweight? Yes No Unsure

Have you ever been diagnosed with obstructive sleep apnea (OSA)? Yes No Unsure

Are you currently being treated for OSA? Yes No Unsure

Are you aware of family history of OSA? Yes No Unsure

Are you aware of clinching/grinding teeth at night?

Yes No Unsure

Do you snore loudly (louder than talking or loud enough to be heard behind a closed door? Yes No Unsure

Dental History

What are the main concerns that you would like orthodontics to accomplish? _____

_____

_____

Have you ever had or been evaluated for orthodontic treatment? Yes No

Have you ever had a serious/difficult problem associated with any dental work? Yes No

Do you now or have you ever experience pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you still have your wisdom teeth? Yes No

Have you have had an injury to Mouth Teeth Chin (circle one)

Do you have any speech problems? _____

Do you generally breath through your mouth? Yes No
(if yes please circle) While Awake While Asleep

Do you have any missing or extra permanent teeth? Yes No

Are you happy with the way your smile looks? Yes No
If not what would you change? _____

_____

I, _____, have had full opportunity to read and consider the content of this consent form and your Notices Privacy Practices. I understand by signing this consent form, I am giving my consent to your use and disclosure of necessary protected health information to carry out treatment, payment activities, and health care options.

Signature:_____ Date:_____

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments: **Initials: _____** **Date: _____**

_____

_____

_____

_____

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 payors 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;
- 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 **April 14, 2003**. 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.