Orthodontic SPECIALISTS

Date _____ Date of Birth _____ Age _____
Name *(first)*_____ *(middle)* _____ *(last)* _____
Address _____ City _____ Zip _____
Email Address_____Cell (Phone) _____
Telephone (Home) _____ Business (Phone)_____
Dentist _____ City _____ Phone _____
Physician _____ City _____ Phone _____
Employed by _____ Occupation_____
Address_____ Social Security No._____
Dental Insurance Information: Name_____ Group No. _____
Medical Insurance Information: Name_____ Group No. _____
Single _____ Married _____ Widowed _____ Divorced _____
Spouse's Name _____ Date of Birth _____ Occupation _____
Employed by _____ City _____ Social Security No. _____
Dental Insurance Information: Name_____ Group No. _____
Medical Insurance Information: Name_____ Group No. _____
Name & Ages of Children _____

## MEDICAL HISTORY

General Health: Good_____ Fair _____ Poor _____
Presently under medical care for _____
Birth defects _____
Medication currently being taken (drug and dose) _____
Allergic to any medication _____
Please check yes or no to the following and date:

| | Yes | No | Year | | Yes | No | Year | | Yes | No | Year | | Yes | No | Year |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Arthritis | ❑ | ❑ | _____ | Emotional | ❑ | ❑ | _____ | Heart disorder/ murmur | ❑ | ❑ | _____ | Rheumatic fever | ❑ | ❑ | _____ |
| Blood/Bleeding problems | ❑ | ❑ | _____ | Endocrine disorder | ❑ | ❑ | _____ | Hepatitis | ❑ | ❑ | _____ | Speech difficulty | ❑ | ❑ | _____ |
| Bone disorder | ❑ | ❑ | _____ | Epilepsy | ❑ | ❑ | _____ | Hospitalized | ❑ | ❑ | _____ | Sexually transmitted disease | ❑ | ❑ | _____ |
| Diabetes | ❑ | ❑ | _____ | Fainting spells | ❑ | ❑ | _____ | | | | | | | | |

❑ ❑ Do you require antibiotic premedication prior to dental appointments? If yes, which antibiotics do you usually take?_____
_____

## DENTAL HISTORY

Date of last dental check-up _____
Injury or trauma to the face or teeth _____
Jaw joint (TMJ problems) noise _____ pain_____ earaches/ringing _____ soreness & stiffness _____
**Have you noticed or been diagnosed as having any of the following problems due to a poor bite?**

| | Yes | No | Year | | Yes | No | Year | | Yes | No | Year |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.** Worn or sore teeth | ❑ | ❑ | ___ | **2.** Bone and gum recession | ❑ | ❑ | ___ | **5.** Speech difficulty | ❑ | ❑ | ___ |
| **2.** Loose teeth | ❑ | ❑ | ___ | **4.** Headaches and or jaw joint problems | ❑ | ❑ | ___ | **6.** Bruxism and or clenching | ❑ | ❑ | ___ |

Is there anything you would like to improve about your dental health, smile, or facial appearance? Describe major reason for seeking orthodontic treatment
_____
Other family members with similar dental conditions and/or orthodontic treatment _____
Have you had any experience with or seen another orthodontist? No / Yes Who? _____
_____
Any additional comments _____
How and when did you first hear about our office? _____
Whom may we thank for referring you to our office? _____

ADULT

PLEASE COMPLETE REVERSE SIDE
OVER ➤

# PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your health information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures, in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or healthcare professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

## PATIENT ACKNOWLEDGEMENT

*Please sign this form below under the heading "acknowledgement" to acknowledge that you have received a copy of our Notice of Privacy Practices.*

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____
Patient/Responsible Party Signature Patient Name (please print)

Date: _____

## PATIENT CONSENT

*Please sign this form below under the heading "Consent" to consent our disclosures of your information that we deem necessary in order to provide you with proper treatment.*

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____
Patient/Responsible Party Signature Patient Name (please print)

Date: _____

***For office use only***
Patient refused to sign

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____

_____ _____
Office Personnel (signature) Office Personnel (print name)

Date: _____