NEW Adult Patient Information

ROUTE 32
PEDIATRIC DENTISTRY & ORTHODONTICS

Patient Information

Patient's Name: _____
last first middle likes to be called

Date of Birth: _____ Age: _____ Sex: _____ E-Mail: _____

Phone: _____ Cell Phone/Alternate Phone: _____

Home Address: _____
street city state zip

Marital Status: ¢ single ¢ married ¢ separated ¢ divorced ¢ remarried ¢ widowed

Patient's Dentist: _____ Referred By: _____ Physician: _____

Names & Ages of Children: _____

_____

Occupation: _____ Work Phone: _____

Employed By: _____

Spouse's Name: _____ Work Phone: _____

Occupation: _____ Employed By: _____

Responsible Party Information

Person Responsible for Account _____
last first middle

Relationship to Patient: _____ Birth date: _____ Soc. Sec. #: _____

Address (if different from patient) _____
street city state zip

Phone: _____ Cell Phone/Alternate Phone: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____
street city state zip

Does the patient have dental Insurance coverage? Yes or No

Dental Insurance Company: _____

Address: _____ Contact #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber #: _____ Group #: _____

Medical History

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Now or in the past, have you had:

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Birth defects or hereditary problems?
- ¢ ¢ ¢ Bone fractures, any major accidents?
- ¢ ¢ ¢ Rheumatoid or arthritic conditions?
- ¢ ¢ ¢ Endocrine or thyroid problems?
- ¢ ¢ ¢ Kidney problems?
- ¢ ¢ ¢ Diabetes?
- ¢ ¢ ¢ Cancer, tumor, radiation treatment or chemotherapy?
- ¢ ¢ ¢ Stomach ulcer or hyperacidity?
- ¢ ¢ ¢ Polio, mononucleosis, tuberculosis, pneumonia?
- ¢ ¢ ¢ Problems of the immune system?
- ¢ ¢ ¢ AIDS or HIV positive?
- ¢ ¢ ¢ Hepatitis, jaundice or liver problem?
- ¢ ¢ ¢ Fainting spells, seizures, epilepsy or neurological problem?
- ¢ ¢ ¢ Mental health disturbance or depression?
- ¢ ¢ ¢ Vision, hearing, tasting or speech difficulties?
- ¢ ¢ ¢ Loss of weight recently, poor appetite?
- ¢ ¢ ¢ History of eating disorder (anorexia, bulimia)?
- ¢ ¢ ¢ Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ¢ ¢ ¢ High or low blood pressure?
- ¢ ¢ ¢ Tired easily?
- ¢ ¢ ¢ Chest pain, shortness of breath or swelling ankles?
- ¢ ¢ ¢ Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- ¢ ¢ ¢ Skin disorder?
- ¢ ¢ ¢ Do you have a well-balanced diet?
- ¢ ¢ ¢ Frequent headaches, colds or sore throats?
- ¢ ¢ ¢ Eye, ear, nose or throat condition?
- ¢ ¢ ¢ Hayfever, asthma, sinus trouble or hives?
- ¢ ¢ ¢ Tonsil or adenoid conditions?
- ¢ ¢ ¢ Osteoporosis?

Allergies or reactions to any of the following:

- ¢ ¢ ¢ Local anesthetics (Novocaine or Lidocaine)
- ¢ ¢ ¢ Aspirin
- ¢ ¢ ¢ Ibuprofen (Motrin, Advil)
- ¢ ¢ ¢ Penicillin or other antibiotics
- ¢ ¢ ¢ Sulfa drugs
- ¢ ¢ ¢ Codeine or other narcotics
- ¢ ¢ ¢ Metals (jewelry, clothing snaps)
- ¢ ¢ ¢ Latex (gloves, balloons)
- ¢ ¢ ¢ Vinyl
- ¢ ¢ ¢ Acrylic
- ¢ ¢ ¢ Animals
- ¢ ¢ ¢ Foods (specify) _____
- ¢ ¢ ¢ Other substances (specify) _____

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for

Medication _____ Taken for _____

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Do you currently have or ever had a substance abuse problem?
- ¢ ¢ ¢ Do you chew or smoke tobacco?
- ¢ ¢ ¢ Operations? Describe: _____
- ¢ ¢ ¢ Hospitalized? For: _____
- ¢ ¢ ¢ Other physical problems or symptoms? Describe: _____
- ¢ ¢ ¢ Being treated by another health care professional? For: _____ Date of most recent physical exam? _____
- ¢ ¢ ¢ Do you have any other medical conditions that we should know about?

Women Only:

- ¢ ¢ ¢ Are you pregnant?
- ¢ ¢ ¢ Are you anticipating becoming pregnant?

Family Medical History:

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain.

¢ Bleeding disorders ¢ Diabetes ¢ Arthritis
¢ Severe allergies ¢ Unusual dental problems
¢ Jaw size imbalance

Any other family medical conditions that we should know about? _____

Dental History

Now or in the past, has the patient had:

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Permanent or "extra" (supernumerary) teeth removed?
- ¢ ¢ ¢ Supernumerary (extra) or congenitally missing teeth?
- ¢ ¢ ¢ Chipped or otherwise injured primary (baby) or permanent teeth?
- ¢ ¢ ¢ Teeth sensitive to hot or cold; teeth throb or ache?
- ¢ ¢ ¢ Jaw fractures, cysts or mouth infections?
- ¢ ¢ ¢ "Dead teeth" or root canals treated?
- ¢ ¢ ¢ Bleeding gums, bad taste or mouth odor?
- ¢ ¢ ¢ Periodontal "gum problems"?
- ¢ ¢ ¢ Food impaction between teeth?
- ¢ ¢ ¢ "Gum boils", frequent canker sores or cold sores?
- ¢ ¢ ¢ Thumb, finger, or sucking habit? Until what age? ____
- ¢ ¢ ¢ Abnormal swallowing habit (tongue thrusting)?
- ¢ ¢ ¢ History of speech problems?
- ¢ ¢ ¢ Mouth breathing habit, snoring or difficulty in breathing?
- ¢ ¢ ¢ Tooth grinding or jaw clenching?
- ¢ ¢ ¢ Any pain, clicking or locking in jaw or ringing in the ears?
- ¢ ¢ ¢ Any pain or soreness in the muscles of the face or around the ears?

yes no dk/u (don't know/understand)

- ¢ ¢ ¢ Difficulty in chewing or jaw opening?
- ¢ ¢ ¢ Have you ever been treated for "TMD" or "TMJ" problems?
- ¢ ¢ ¢ Aware of loose, broken or missing restorations (fillings)?
- ¢ ¢ ¢ Any teeth irritating cheek, lip, tongue or palate?
- ¢ ¢ ¢ Concerned about spaced, crooked or protruding teeth?
- ¢ ¢ ¢ Aware or concerned about under or over developed jaw?
- ¢ ¢ ¢ Any relative with similar tooth or jaw relationships?
- ¢ ¢ ¢ Any wisdom tooth problems?
- ¢ ¢ ¢ Had periodontal (gum) treatment?
- ¢ ¢ ¢ Had any serious trouble associated with any previous dental treatment?
- ¢ ¢ ¢ Been under another dentist's care?
  Specialist _____
  Other _____
- ¢ ¢ ¢ Ever had a prior orthodontic examination or treatment?
- ¢ ¢ ¢ Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ floss: _____

What is your primary concern? _____

Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed _____
(Dental staff member)

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Privacy Consent

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

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 in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's Signature _____

Print Name _____

Date _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name

_____

Signature

_____

Date

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ¢ Individual refused to sign
- ¢ Communications barriers prohibited obtaining the acknowledgement
- ¢ An emergency situation prevented us from obtaining acknowledgement
- ¢ Other (please specify)

_____

_____

_____