PATIENT INFORMATION

Today's Date_____ ❑ Male ❑ Female

Name _____

Common Name _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip_____

Best Daytime Number _____

❑ Home ❑ Cell ❑ Work

Patient Email _____

School _____

Patient's Hobbies/Interests _____

How did you decide to come to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____

Relationship to Patient _____

SSN _____

Address _____

City _____ State _____ Zip_____

Employer _____

Occupation _____

Phone _____

❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed

Responsible Party's Email _____

Spouse/Other Name _____

Relationship to Patient _____

SSN _____

Address _____

City _____ State _____ Zip_____

Employer _____

Occupation _____

Phone _____

Are there any other family members that need an exam? ❑ Yes ❑No

Relatives or friends previously treated here _____

_____

DURALL WEDDING ORTHODONTICS

MEDICAL/DENTAL HISTORY

General Dentist _____

Last Dental Visit_____

Patient's attitude toward orthodontic treatment

❑ Wants it Done ❑ Doesn't Want It ❑ No Preference

Has orthodontist been consulted previously? ❑ Yes ❑ No

Is the patient under the care of a physician for a specific problem at this time?_____

Physician's Name _____

Are you taking any prescription medication? ❑ Yes ❑ No

If so, which ones? _____

Are you currently taking a bisphosphonate for osteoporosis?

❑ Yes ❑ No ❑ Fosamax ❑ Boniva ❑ Actonel ❑ Other

List any drug sensitivities _____

Do you require pre-medication prior to dental procedures?

❑ Yes ❑ No

Please check all of the following that apply

❑ Latex Allergy	❑ Jaw Joint Pain	❑ Teeth Grinding
❑ Diabetes	❑ Bone Disorders	❑ Heart Condition
❑ Epilepsy	❑ ADD/ADHD	❑ Kidney Problems
❑ Hepatitis	❑ AIDS/HIV	❑ Endocrine Problems
❑ Asthma	❑ Ear/Tonsil Issues	❑ Emotional Problems
❑ Mouth Breathing	❑ Face, Mouth or Teeth Injuries	
❑ Extracted Teeth	❑ Family History of Underbite	
❑ Speech Therapy	❑ Thumb/Finger Sucking Habit	

List any other serious medical issues _____

List any allergies _____

DENTAL INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No

Insured's Name _____

SSN _____

Employer _____

Insurance Company _____

Date of Birth _____ ID _____

Insurance Phone _____

Secondary Dental Insurance? ❑ Yes ❑ No

Insured's Name _____

SSN _____

Employer _____

Insurance Company _____

Date of Birth _____ ID _____

Insurance Phone _____

DURALL WEDDING ORTHODONTICS

Member American Association of Orthodontists®

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 or 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 inquires 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 over heard by other patients and third parties.

This privacy notice is effective as of the date of your signature. 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.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient _____ Date _____