

PATIENT INFORMATION SHEET

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

CITY/ST _____ **ZIP** _____

PHONE _____ **SCHOOL** _____ **GRADE:** _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

Do you have a promo code? _____

Do you have a gift card? _____

Please provide your email and phone number with cell phone provider.....

Email: _____

Text message: _____ **Choose one: AT&T, Sprint, T-Mobile, Other** _____

PERSON/PARENT RESPONSIBLE FOR ACCOUNT

NAME _____ **ADDRESS** _____

CITY/ST _____ **ZIP** _____

HOME# _____ **CELL** _____ **WK** _____

DOB _____ **RELATIONSHIP TO PATIENT** _____

INSURANCE COMPANY _____ **TEL. #** _____

POLICY HOLDER _____ **DOB** _____

SS#/ID # _____ **GROUP#** _____

Privacy Consent

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care options (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's policy 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.

Patient's Signature (Parent if minor)

Print Name

Date

HEALTH HISTORY

CIRCLE ONE

IS PT IN GOOD HEALTH?	YES	NO
HAVE TONSILS AND ADENOIDS BEEN REMOVED?	YES	NO
HAS PT EVER SUCKED HIS/HER FINGER OR THUMB? UNTIL WHAT AGE?	YES	NO
DOES PT HAVE ANY SPEECH PROBLEMS?	YES	NO
DOES PATIENT PLAY A WIND INSTRUMENT? WHAT INSTRUMENT?	YES	NO
DOES PT HAVE A HISTORY OF A MAJOR CONDITION OR ILLNESS? IF YES, LIST _____	YES	NO
IS PATIENT CURRENTLY TAKING ANY MEDICATION? IF YES, LIST _____	YES	NO
PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITIES _____		
IF YOU ARE FEMALE, HAVE YOU STARTED YOUR PERIOD?	YES	NO
IF SO MORE THAN A YEAR AGO?	YES	NO
ARE YOU CURRENTLY PREGNANT?	YES	NO
IS THE PATIENT A SODA DRINKER? IF YES, COKE, DR. PEPPER, PEPSI, SPRITE OTHER _____	YES	NO
PLEASE CIRCLE IF THE PATIENT HAS ANY HISTORY OF:		
Rheumatic Fever Diabetes Asthma Heart Murmur Tuberculosis Sinusitis Seizures/Convulsions Heart Problems Aids/Hiv+ Venereal Disease Hepatitis Psychiatric Care Artificial Joints or Valves		

Current General Dentist _____ Last cleaning _____

Please list any other information we may need to know: _____

THANK YOU FOR TAKING THE TIME TO FILL OUT THE ABOVE INFORMATION. IT WILL ASSIST US IN THE TREATMENT OF YOU/YOUR CHILD. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK.