DOMINION ORTHODONTICS, PC — Patient Information Form

Date:________

Patient's Name:______________________ Sex:________ Age:________ Birthday:______________

Nickname:______________________ Phone:______________________

Address:______________________ City:______________ State:__________ Zip:____________

Referred to our office by:______________________________________

If student, school or college:______________________ Grade:__________

Employed by:______________________ ☐ N/A Occupation:______________ Work Phone:______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

If Minor, Parent/Guardian Name:______________________ Occupation:______________ Work Phone:______________

Address, if different from above:______________________ City:______________ State:__________ Zip:____________

Person Responsible for Account: ☐ Self ☐ Parent ☐ Spouse ☐ Guardian ☐ Other SSN:______________ DOB:__________

Responsible Person's Name, if different from above:______________________________________

Address, if different from above:______________________ City:______________ State:__________ Zip:____________

E-Mail Address:______________________

Additional Siblings - Names/Ages:______________________________________

*Patient's Dentist:*______________________ *Date of Last Visit:*______________________

DENTAL INSURANCE

Employer:______________________ Orthodontic Coverage:

Primary Insurance Company:______________________ Group #:______________ ☐ Yes ☐ No

Insured's Name:______________________ ID# or SSN:______________ Birthdate:______________

Employer:______________________ Orthodontic Coverage:

Secondary Insurance Company:______________________ Group#:______________ ☐ Yes ☐ No

Insured's Name:______________________ ______________ ID# or SSN:______________ Birthdate:______________

DENTAL HISTORY

1. Reason for consultation (chief concern):______________________________________
2. Has the patient had any injuries to the face, mouth or teeth? ☐ YES ☐ NO
3. Has the patient been informed of any missing or extra permanent teeth? ☐ YES ☐ NO
4. Has an orthodontist been consulted previously? ☐ YES ☐ NO Name:______________ Date:__________
5. Does the patient have any speech problems? ☐ YES ☐ NO
6. Does the patient have any jaw joint noise/clicking or discomfort moving his/her jaws? ☐ YES ☐ NO
7. Is the patient frightened or anxious about orthodontic treatment? ☐ YES ☐ NO
8. Does the patient like his/her smile? ☐ YES ☐ NO
9. Has there ever been any orthodontic treatment for any other member of the family? If so, whom:______________________ ☐ YES ☐ NO
10. Has the patient ever had any prolonged habits? ☐ None ☐ Thumb, finger or pacifier sucking ☐ Grinding of teeth at night ☐ Mouth breathing ☐ Snoring ☐ Lip biting
11. Has the patient ever been treated for any of these? ☐ None ☐ Bad Bite ☐ TMJ ☐ Periodontal Disease If so, by whom?______________________

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MEDICAL HISTORY

#	Question	YES	NO
1.	Is the patient's general health good at this time? If no, please explain:________________________________	☐ YES	☐ NO
2.	Is the patient under the care of a physician at this time? If yes, please explain:________________________________	☐ YES	☐ NO
3.	Is the patient taking any medication? If yes, please list:________________________________	☐ YES	☐ NO
4.	Has the patient ever had a serious illness or been hospitalized? If yes, please explain:________________________________	☐ YES	☐ NO
5.	Is the patient allergic to any medication(s) (Penicillin, Sulfa, Aspirin, etc.)? If yes, please list medication(s)________________	☐ YES	☐ NO
6.	Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method:________________	☐ YES	☐ NO
7.	Has the patient had tonsils and/or adenoids removed? If yes, at what age:________________________	☐ YES	☐ NO
8.	Does the patient have any other special problems not listed? If yes, please explain:________________________________	☐ YES	☐ NO
	ADOLESCENT PATIENTS:		
9.	Has the patient shown signs of increased growth recently?	☐ YES	☐ NO
10.	Has the patient reached puberty?	☐ YES	☐ NO
	Girls – started menstruating?	☐ YES	☐ NO
	Boys – voice change?	☐ YES	☐ NO
	WOMEN:		
11.	Are you pregnant or considering pregnancy within the next two (2) years?	☐ YES	☐ NO
12.	Are you nursing?	☐ YES	☐ NO
13.	Are you currently taking medication for birth control?	☐ YES	☐ NO

DO YOU NOW HAVE, OR HAVE EVER HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		NOTE:
☐Yes	☐No	TUBERCULOSIS	☐Yes	☐No	HERPES (ORAL COLD SORES)	________
☐Yes	☐No	ENDOCARDITIS	☐Yes	☐No	BLOOD DISORDERS/BLEEDING PROBLEMS	________
☐Yes	☐No	HEART CONDITION/DISEASE/SURGERY	☐Yes	☐No	ARTHRITIS	________
☐Yes	☐No	HEART PACEMAKER	☐Yes	☐No	ULCERS	________
☐Yes	☐No	HEART MURMUR	☐Yes	☐No	STROKE	________
☐Yes	☐No	HEART ATTACK (CORONARY)	☐Yes	☐No	ANEMIA	________
☐Yes	☐No	CONGENITAL HEART DISEASE	☐Yes	☐No	ASTHMA	________
☐Yes	☐No	RHEUMATIC FEVER	☐Yes	☐No	EPILEPSY/SEIZURES	________
☐Yes	☐No	PROSTHETIC (ARTIFICIAL) JOINT	☐Yes	☐No	GLAUCOMA	________
☐Yes	☐No	X-RAY/RADIATION (CANCER) THERAPY	☐Yes	☐No	FAINTING SPELLS	________
☐Yes	☐No	AIDS OR H.I.V. POSITIVE	☐Yes	☐No	ADD	________
☐Yes	☐No	DIABETES	☐Yes	☐No	KIDNEY TROUBLE	________
☐Yes	☐No	HIGH BLOOD PRESSURE	☐Yes	☐No	LIVER DISEASE	________
☐Yes	☐No	LOW BLOOD PRESSURE	☐Yes	☐No	PSYCHIATRIC TREATMENT	________
☐Yes	☐No	HEPATITIS (TYPE:__________)	☐Yes	☐No	DRUG ADDICTION	________
☐Yes	☐No	VENEREAL DISEASE	☐Yes	☐No	CIGARETTE SMOKING/CHEWING Tobacco	________
☐Yes	☐No	ALLERGIES	☐Yes	☐No	EMOTIONAL PROBLEMS	________
☐Yes	☐No	ALLERGIES TO METAL	☐Yes	☐No	OTHER:________________	
☐Yes	☐No	ALLERGIES TO LATEX	☐Yes	☐No	OTHER:________________	

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I authorize the Doctor and Staff to release any information including the diagnosis and the records or any treatment or examination rendered to me or my child during the period of such orthodontic care to the third party payers and/or other health practitioners.

Signatures	*For office use only:*
Signature of Patient/Parent/Guardian: ________________________________ Date	Today's Date:________________________
Signature of Orthodontist: ________________________________ Date	Update:____________ Initial:____________ Update:____________ Initial:____________ Update:____________ Initial:____________

NOTES:

DOMINION ORTHODONTICS, PC **Patient Information Form** **Date:________**

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: _______________________________ Date of Birth: _____________________

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient:

Name	Relationship
_________________________________	_______________________________
_________________________________	_______________________________
_________________________________	_______________________________

Or

_________ Initial here if you do not wish to release you/or your childs protected information to anyone.

This authorization permits **Dominion Orthodontics** to use and/or disclose the following individually identifiable health information about myself/or my child. It is understood that Dominion Orthodontics will only disclose information relevant to current treatment.

Signature: _____________________________________ Date: ________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

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

Signature: _____________________________________ Date: ________________

FOR OFFICE USE ONLY

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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 prohibited us from obtaining acknowledgement
__Other (Please specify)