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 ☐ Lip biting ☐ Snoring ☐ Grinding of teeth at night ☐ Mouth breathing
11. Has the patient ever been treated for any of these? ☐ Bad Bite ☐ TMJ ☐ Periodontal Disease If so, by whom?_____

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MEDICAL HISTORY

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.	Do you have a family physician?_____	☐ YES	☐ NO
4.	Is the patient taking any medication? If yes, please list:_____	☐ YES	☐ NO
5.	Has the patient ever had a serious illness or been hospitalized? If yes, please explain:_____	☐ YES	☐ NO
6.	Is the patient allergic to any medication(s) (Penicillin, Sulfa, Aspirin, etc.)? If yes, please list medication(s)_____	☐ YES	☐ NO
7.	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
8.	Has the patient had tonsils and/or adenoids removed? If yes, at what age:_____	☐ YES	☐ NO
9.	Does the patient have any other special problems not listed? If yes, please explain:_____	☐ YES	☐ NO
	ADOLESCENT PATIENTS:		
10.	Has the patient shown signs of increased growth recently?	☐ YES	☐ NO
11.	Has the patient reached puberty?	☐ YES	☐ NO
	Girls – started menstruating?	☐ YES	☐ NO
	Boys – voice change?	☐ YES	☐ NO
	WOMEN:		
12.	Are you pregnant or considering pregnancy within the next two (2) years?	☐ YES	☐ NO
13.	Are you nursing?	☐ YES	☐ NO
14.	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:
☐	☐	TUBERCULOSIS	☐	☐	HERPES (ORAL COLD SORES)	_____
☐	☐	ENDOCARDITIS	☐	☐	BLOOD DISORDERS/BLEEDING PROBLEMS	_____
☐	☐	HEART CONDITION/DISEASE/SURGERY	☐	☐	ARTHRITIS	_____
☐	☐	HEART PACEMAKER	☐	☐	ULCERS	_____
☐	☐	HEART MURMUR	☐	☐	STROKE	_____
☐	☐	HEART ATTACK (CORONARY)	☐	☐	ANEMIA	_____
☐	☐	CONGENITAL HEART DISEASE	☐	☐	ASTHMA	_____
☐	☐	RHEUMATIC FEVER	☐	☐	EPILEPSY/SEIZURES	_____
☐	☐	PROSTHETIC (ARTIFICIAL) JOINT	☐	☐	GLAUCOMA	_____
☐	☐	X-RAY/RADIATION (CANCER) THERAPY	☐	☐	FAINTING SPELLS	_____
☐	☐	AIDS OR H.I.V. POSITIVE	☐	☐	ADD	_____
☐	☐	DIABETES	☐	☐	KIDNEY TROUBLE	_____
☐	☐	HIGH BLOOD PRESSURE	☐	☐	LIVER DISEASE	_____
☐	☐	LOW BLOOD PRESSURE	☐	☐	PSYCHIATRIC TREATMENT	_____
☐	☐	HEPATITIS (TYPE:_____)	☐	☐	DRUG ADDICTION	_____
☐	☐	VENEREAL DISEASE	☐	☐	CIGARETTE SMOKING/CHEWING TOBACCO	_____
☐	☐	ALLERGIES	☐	☐	EMOTIONAL PROBLEMS	_____
☐	☐	ALLERGIES TO METAL	☐	☐	OTHER:_____	
☐	☐	ALLERGIES TO LATEX	☐	☐	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.

Signature of Patient/Parent/Guardian:

_____ Date

Signature of Orthodontist:

_____ Date

For office use only:

Today's Date:_____
Update:_____ Initial:_____
Update:_____ Initial:_____
Update:_____ Initial:_____

NOTES:

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

DOMINION ORTHODONTICS

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

_____

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)