ADULT PATIENT INFORMATION

Tell us about yourself

Patient's Name: ______________________________ DOB:_________

Age: _________

Preferred Name: _______________ ☐ Male ☐ Female

Home #:________________ Cell#:_______________

Email: ____

Occupation: ____

Hobbies/ Special Interests: ___________________________

Whom may we thank for referring you? ____________

General Dentist: _________________________

General Dentist #: ________________________

Date of last visit: _________________________

Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Spouse's Information

Name: _________________________

Work #: _____________________ Home#________________

Employer: ___________________________________

SS#: _________________________

Account Holder Information

Name: ____

Billing Address: ______________________________________

____

City State Zip

Work #: __________________ Home #____________________

Cell #: __________________________________

Email: __________________________________

Employer: ______________________________

Primary Dental Insurance

Ins Name: _____________________________________

Ins Address: ___________________________________

____

Ins Co #: ______________________________________

Group/Policy #_____________________________________

Insured's Name: __________________________________

Relationship to Patient: ______________________________

Insured's DOB: __________ Insured's SSN: _____________

Insured's Employer: ____________________________

Secondary Dental Insurance

Ins Name: ______________________________________

Ins Address: ____________________________________

____

Ins Co #: ______________________________________

Group/Policy #_____________________________________

Insured's Name: __________________________________

Relationship to Patient: ______________________________

Insured's DOB: __________ Insured's SSN: _____________

Insured's Employer: ________________________________

ADULT PATIENT INFORMATION

What are the main concerns you would like orthodontics to accomplish?

____

Has you been evaluated or had orthodontic treatment before?

☐ Yes ☐ No- if yes, Who?______________________

Have there been any injuries to the face, mouth, teeth or chin?

☐ Yes ☐ No

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth?

☐ Yes ☐ No

Have you had any pain/tenderness in the jaw? ☐ Yes ☐ No

Do you brush your teeth twice daily? ☐ Yes ☐ No

Floss your teeth daily? ☐ Yes ☐ No

Please list any musical instruments you play:

____

Do you exhibit any of the following behaviors?

YES	NO	
☐	☐	Nail Biting
☐	☐	Thumb Sucking
☐	☐	Teeth Grinding (Bruxism)
☐	☐	Open Mouth Breathing
☐	☐	Speech Impairment
☐	☐	Tongue Thrust (reverse swallow)

Medical History Updates:

Initial: _________________ Date: __________

Initial: _________________ Date: __________

Our office is committed to meeting and exceeding standards of infection control as mandated by OSHA, the CDC, and the ADA.

Health History

YES	NO		YES	NO	
☐	☐	Heart Disease	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Anemia
☐	☐	HIV+/AIDS	☐	☐	Endocrine/Thyroid
☐	☐	Hemophilia	☐	☐	Hospital Stays
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis	☐	☐	Allergies to Any Drug
☐	☐	Arthritis	☐	☐	Sleep Apnea

Please list any serious medical problems that you have had:

____

Do you normally pre-medicate before each dental visit?

☐ Yes ☐ No

Do you take any bisphosphonate medications for bone disorders, such as Fosamax? ☐ Yes ☐ No

Please list and provide reasoning for any medications that are currently being taken:

____

Please list any allergies or drug sensitivity:

____

It is my understanding that the information I have given today is correct to the best of my knowledge. I am also aware that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I hereby authorize the staff at Buckhead Orthodontics to perform any necessary orthodontic services with my informed consent that I may need during diagnosis and treatment.

Signature: ____________________________________

Date:

Transfer Patients Only:

I hereby authorize the transfer of my orthodontic records to Michael B. Everson, DDS, MS.

Signature: ________________________________

Date: ______________

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtaining payment from third party payers (e.g. insurance company)
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: ____

Relationship to Patient: ____

Signature: _________________________________ Date: ____________________