PATIENT INFORMATION SHEET

PATIENT NAME: _____DATE: _____

EMAIL ADDRESS: _____

ADDRESS: _____

CITY/ST_____ZIP_____

PHONE_____DOB_____

SCHOOL_____ GRADE: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PERSON/PARENT RESPONSIBLE FOR ACCOUNT

NAME_____ADDRESS_____

CITY/ST_____ZIP_____

HOME#_____CELL_____WK_____

DOB_____REL TO PT_____

CONFIRMATION EMAIL ADDRESS: _____

INSURANCE CO_____TEL. #_____

POLICY HOLDER_____DOB_____

SS#/ID #_____DL #_____

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**
HAS THE ERUPTION OF THE TEETH SEEMED NORMAL? EARLY_____LATE_____	**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, ARE YOU PREGNANT?	**YES**	**NO**
IS THE PATIENT A SODA DRINKER? IF YES, LIST MOST FREQUENT_____AND HOW MANY DAILY_____	**YES**	**NO**
PLEASE CIRCLE IF YOU HAVE ANY HISTORY		
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.