Family ORTHODONTICS

Welcome to our office! So that we can best meet your orthodontic needs, please complete both sides of this medical/dental questionnaire. When you have finished, please return it to one of our staff members and we will be with you shortly.

PATIENT INFORMATION

Name: _____ Birthday: _____
FIRST MI LAST NICKNAME

Address: _____
CITY STATE ZIP

WHAT IS THE BEST WAY TO CONTACT YOU?

☐ Home phone # :_____

☐ Cell phone # :_____ ☐ Text to confirm appts

☐ Work / other phone # :_____

☐ E-Mail : _____ ☐ E-Mail to confirm appts

INSURANCE INFORMATION

Do you have Dental/Orthodontic Insurance? ☐ YES ☐ NO ☐ NOT SURE

Primary insurance carrier? ☐ SELF ☐ SPOUSE ☐ PARENT

If you selected spouse or parent, please provide their name and social security number (required):

_____

Insurance Co. Name:_____

Member / Policy id #: _____Group #: _____

Provider Phone #:_____

OTHER INFORMATION

How did you hear about our office?

_____

_____

General dentist name and address: _____

Have they taken X-rays in the past 6 months ? _____

Primary care physicians name: _____

Do you have any siblings or family members who are or have been treated in this office: _____

_____

Family ORTHODONTICS

Patient Medical History

Y N Are you in good health?
Y N Are you under the care of a physician?
If so, for what reason?_____
_____
Y N Are you taking any medications?
If so, please list: _____
_____
Y N Do you have any allergies?
If so, please list: _____
_____

Do you have a history of:

Y	N	Asthma	Y	N	Sleep apnea
Y	N	Breathing problems	Y	N	Mouth breathing
Y	N	Trouble swallowing	Y	N	Ear problems
Y	N	Tonsils or adenoids removed	Y	N	Speech problems
Y	N	Heart problems	Y	N	Rheumatic fever
Y	N	Seizures/Epilepsy	Y	N	Diabetes
Y	N	Prolonged bleeding	Y	N	HIV or Hepatitis

Patient Dental History

Y N Have you had a recent dental check-up? If so, when? _____
Y N Have you had previous orthodontic treatment or an orthodontic evaluation?
If so, when and where? _____
Y N Does anyone else in the family have a similar bite?
If so, who? _____
Y N Is the patient adopted?

Do you have a history of:

Y N Trauma to the face or teeth
Y N Thumb or finger sucking habit
Y N Night time teeth grinding habit
Y N Loss of permanent teeth
Y N Cleft lip or palate
Y N Pain or tenderness in the jaw joints
Y N Sounds of clicking in the jaw joints when opening or closing
Y N Difficulty chewing or eating
Y N Sores or ulcers in the mouth
Y N Cold sores or fever blisters
Y N Endodontic treatment/root canal therapy
Y N Dental crowns or bridges
Y N Dental implants

SIGNATURE:_____DATE:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security#:_____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice Accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Family Orthodontics
Telephone 561-744-5456 Fax 561-7 44-9803
E-mail: Frontdesk@westfamilyortho.com
Address: 1851 W. Indiantown Road, Suite #201, Jupiter, Florida 33458

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I _____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date:_____