PATIENT INFORMATION

DATE _____

□ Dr. □ Mr. □ Mrs. □ Ms. □ Miss

NAME_____ NICKNAME _____

BIRTHDATE_____ AGE_____ GENDER □ MALE □ FEMALE

ADDRESS _____

_____

PHONE (home) _____ (cell) _____Carrier_____

EMAIL ADDRESS _____

Please select your preferred method of future appointment notification and office information: □ Phone call □ E-Mail □ Text □ Mail

WHOM MAY WE THANK FOR REFERRING YOU? _____

WHO SUGGESTED THAT YOU MIGHT NEED ORTHODONTIC TREATMENT? _____

HAS THE PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? □ YES □ NO IF SO, WHERE? _____

MAIN REASON FOR SEEKING ORTHODONTIC TREATMENT _____

RESPONSIBLE PARTY/FAMILY INFORMATION

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS (IF DIFFERENT THAN ABOVE) _____

_____

PHONE (home) _____ (cell) _____Carrier_____

BIRTHDATE _____ SOCIAL SECURITY # _____

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

NAME _____Relationship to Patient_____

ADDRESS (IF DIFFERENT THAN ABOVE) _____

PHONE (home) _____ (cell) _____Carrier_____

BIRTHDATE _____ SOCIAL SECURITY # _____

NAME _____Relationship to Patient_____

ADDRESS (IF DIFFERENT THAN ABOVE) _____

PHONE (home) _____ (cell) _____Carrier_____

BIRTHDATE _____ SOCIAL SECURITY # _____

DENTAL INSURANCE INFORMATION

INSURED'S NAME _____ INSURED'S SOCIAL SECURITY # _____

BIRTHDATE _____ EMPLOYER_____

INSURANCE COMPANY _____GROUP # _____ ID _____

INSURANCE CO. ADDRESS _____ PHONE NO. _____

DO YOU HAVE DUAL COVERAGE? □ YES □ NO

IF YES:

INSURED'S NAME _____ INSURED SOCIAL SECURITY # _____

BIRTHDATE _____ EMPLOYER_____

INSURANCE COMPANY _____GROUP # _____ ID _____

INSURANCE CO. ADDRESS _____ PHONE NO. _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____

PHONE (home) _____ (cell) _____

FUN FACTS

WHAT WOULD YOU LIKE TO SEE IN YOUR ORTHODONTIST? _____

FAVORITE HOBBY _____ FAVORITE FOOD _____

FAVORITE STORE _____ FAVORITE RESTAURANT_____

FAVORITE SPORT _____ FAVORITE TEAM _____

FAVORITE MUSICAL ARTIST _____

ANY OTHER INFORMATION YOU WOULD LIKE US TO KNOW _____

_____

_____

_____

_____

MEDICAL HISTORY

PHYSCIAN'S NAME _____ DATE OF LAST VISIT _____

ADDRESS _____ PHONE _____

PLEASE CIRCLE YES OR NO (IF YES, PLEASE FILL IN DETAILS). PARENTS/GUARDIANS PLEASE RESPOND FOR MINORS.

YES NO ARE YOU TAKING ANY MEDICATIONS/SUPPLEMEMNTS/HERBALS? _____

YES NO ARE YOU ALLERGIC TO ANY MEDICATION/FOOD/LATEX/METALS/ACRYLICS/ANESTHETICS ETC? _____

YES NO DO YOU HAVE A HISTORY OF A MAJOR ILLNESS? _____

YES NO HAVE YOU HAD ANY MAJOR OPERATIONS? _____

YES NO HAVE YOU EVER BEEN INVOLVED IN A SERIOUS ACCIDENT? _____

YES NO ARE YOU/HAVE YOU TAKING/TAKEN BISPHOSPHONATES FOR OSTEOPOROSIS OR OTHER BONE DISEASES? _____

YES NO DO YOU CHEW OR SMOKE TOBACCO PRODUCTS? IF SO, HOW LONG? _____

CIRCLE ANY OF THE MEDICAL CONDITIONS BELOW THAT YOU HAVE HAD OR CURRENTLY HAVE.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged bleeding
Arthritis	Epilepsy	High blood pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal disorders	HIV/AIDS	Rheumatic fever
Bone disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital heart defect	Heart murmur	Nervous disorder	Tumor or Cancer

ARE THERE ANY MEDICAL CONDITIONS WE HAVE NOT DISCUSSED THAT YOU FEEL WE SHOULD BE AWARE OF? _____

_____

DOES YOUR PHYSICIAN RECOMMEND PREMEDICATING WITH ANTIBIOTICS PRIOR TO DENTAL PROCEDURES? _____

DENTAL HISTORY

DENTIST _____CITY/LOCATION_____ DATE OF LAST VISIT _____

PLEASE CIRCLE YES OR NO (IF YES, PLEASE FILL IN DETAILS). PARENTS/GUARDIANS PLEASE RESPOND FOR MINORS.

YES NO ARE YOU UNHAPPY WITH THE APPEARANCE OF YOUR TEETH? _____

YES NO ARE YOU PRESENTLY IN ANY DENTAL PAIN? _____

YES NO HAVE YOU EVER EXPERIENCED ANY UNFAVORABLE REACTION TO DENISTRY? _____

YES NO HAVE YOU EVER LOST OR CHIPPED ANY TEETH? _____

YES NO HAVE THERE BEEN ANY INJURIES TO FACE, MOUTH OR TEETH? _____

YES NO IS ANY PART OF YOUR MOUTH SENSITIVE TO TEMPERATURE OR PRESSURE? _____

YES NO DO YOUR GUMS BLEED WHEN YOU BRUSH? _____

YES NO DO YOU HAVE ANY TYPE OF THUMB OR TONGUE HABIT? _____

YES NO ARE YOU A MOUTH BREATHER? _____

YES NO DO YOU HAVE/HAVE YOU HAD A TONSIL OR ADENOID CONDITION? _____

YES NO HAVE YOU BEEN TOLD YOU HAVE A TONGUE THRUST? _____

YES NO HAVE YOU EVER SEEN AN ORTHODONTIST? IF YES, WHO & WHEN? _____

YES NO DO YOU HAVE A POSITIVE ATTITUDE TOWARDS RECEIVING ORTHODONTIC TREATMENT? IF NO, WHY? _____

YES NO HAS ANYONE IN YOUR FAMILY RECEIVED ORTHODONTIC TREATMENT? _____

HOW DID THEY FEEL ABOUT THE RESULT? _____

YES NO DO YOUR TEETH OR JAW EVER FEEL UNCOMFORTABLE WHEN YOU AWAKE IN THE MORNING? _____

YES NO ARE YOU AWARE OF YOUR JAW CLICKING OR POPPING? _____

YES NO ARE YOU AWARE OF CLENCHING YOUR TEETH DURUNG THE DAY? _____

YES NO HAVE YOU EVER BEEN TOLD THAT YOU GRIND YOUR TEETH? _____

YES NO DO YOU HAVE "TENSION" HEADACHES? _____

YES NO HAVE YOU EVER EXPERIENCED CHRONIC RINGING IN YOUR EARS? _____

YES NO ARE THERE ANY FAMILIAL MEDICAL CONDITIONS WE SHOULD KNOW ABOUT? _____

FEMALE PATIENTS

HAS MENSTRUATION STARTED (This is useful in the monitoring/modifying growth of head & jaw bones) □ YES □ NO AGE STARTED _____

IS IT POSSIBLE THE PATIENT IS PREGNANT? □ YES □ NO

I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. I WILL NOT HOLD BIETSCH ORTHODONTICS RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM. IF THERE ARE ANY CHANGES TO THE MEDICAL OR DENTAL HISTORY, I WILL SO INFORM THIS PRACTICE. I AUTHOURIZE BIETSCH ORTHODONTICS TO PERFORM THE NECESSARY ORTHODONTIC SERVICES I MAY NEED DURING TREATMENT.

SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA FORM)

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practies (HIPAA FORM).

Print Name: _____ Signature:_____ Date: _____

FOR OFFICE USE ONLY: I HAVE VERBALLY REVIEWED THE MEDICAL AND DENTAL INFORMATION ABOVE WITH THE PATIENT/GUARDIAN.

DOCTOR'S SIGNATURE _____DATE _____

MEDICAL HISTORY UPDATED ON : DATE _____ UPDATED BY _____

DOCTOR'S SIGNATURE _____

We attempted to obtain written acknowledgement of Receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

_____ Individual refused to sign _____ Communication barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement _____ Other (Please Specify) _____

Office Initials _____