Date: ____

Patient ID # ____

Patient Information

First Name		Last Name	Name to be called	Date of Birth
Age	Sex	Social Security Number	Email Address	

Address (Please no PO Box)	City	State	Zip

Home Phone	Work Phone	Cell Phone	Cell Phone Service Provider
Best Contact Number (circle one) Home Cell Work	Employer	Position	How Long?

How did you hear about our office?	Relatives who are (were) patients of Smithfield Orthodontics

In case of emergency please notify	Relationship to Patient	Phone No.

Spouse Information

Marital Status				
Spouse First Name	Last Name	Date of Birth	Email Address	Social Security #
Address				

Home Phone	Work Phone	Cell Phone	Cell Service Provider
Employer	Position	How Long?	

Other Responsible Party Information

Name	Date of Birth	Email Address	Social Security #
Address			

Home Phone	Work Phone	Cell Phone	Cell Phone Service Provider
Employer	Position	How Long?	

Name of the person who will be financially responsible for this account:

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Patient Name: ____

Medical History: For any of those below to which you answer yes, PLEASE LIST.

Physician's Name: ____

Yes No Are you taking any medications/supplements /herbals? List:________________________________
Yes No Are you allergic to any medication /foods/latex/metals/acrylics/anesthetics/etc? List:________________
Yes No Have you had a history of a major illness? List:________ ________________________________
Yes No Have you had any major operations? List: ________________________________
Yes No Have you ever been involved in a serious accident? List: ________________________________
Yes No Have you ever taken bisphosphonates for osteoporosis or other bone diseases? List:________________
Yes No Do you chew or smoke tobacco products? If so, how long? ________________________________
Yes No Are you pregnant? If Yes, please list due date:________________________________
Yes No Do you or have you ever had a substance abuse problem?
Yes No Has a physician ever recommended that antibiotics be taken prior to dental procedures?

Check any of the medical conditions below that you have had or currently have:

☐Kidney Problems
☐Tuberculosis
☐Rheumatic Fever
☐Radiation / Chemo
☐Diabetes Type _____
☐Congenital Heart Defect
☐Bone Disorders
☐Pneumonia
☐Tumor or Cancer
☐HIV/AIDS
☐High Blood Pressure
☐Herpes
☐Hepatitis Type ____
☐Asthma
☐Hay Fever
☐Arthritis
☐Anemia
☐Heart Murmur
☐Gastrointestinal Disorders
☐Nervous Disorders
☐Heart Problem
☐Epilepsy
☐Dizziness
☐ Bleeding/Hemophilia

Any conditions not listed above that we should be aware of? ________________________________

Dental History: For any of those below to which you answer yes, PLEASE LIST.

Dentist's Name: ________________________________Date of Last Exam/Cleaning: __________

Yes No Did your general dentist refer you for this consultation? If yes, please describe the dentist's orthodontic concerns:
____
Yes No Do you have any dental work recommended by the dentist that has not yet been completed? If Yes, circle all that apply:
Cleaning, Filling, Crown, Bridge, Implant, Extraction, Other: ________________________________
Yes No Have you had an adverse reaction to any dental procedure? Details:________________________________
Yes No Have you received orthodontic treatment in the past? Details: ________________________________
Yes No Have you visited another orthodontist for a new patient exam/consultation? Dr. Name:________________
What are you hoping for orthodontics to correct?________________________________

Check any of the dental conditions below that you have had or currently have:

☐Bad Breath
☐Chipped Tooth/Teeth
☐Dental Pain
☐Extraction Baby Teeth
☐Extraction Adult Teeth
☐Gum Bleeding
☐Gum Inflammation
☐Gum Recession
☐Finger/Thumb Sucking
☐Tongue Thrust
☐Lip Sucking/Biting
☐Strong Gag Reflex
☐Head/Facial Injury
☐Mouth/Chin/Jaw Injury
☐Teeth Injury
☐Jaw Clicking /Popping
☐Jaw Locking
☐Snoring
☐Jaw Pain
☐Mouth Breather
☐Pressure Sensitivity
☐Temperature Sensitivity
☐Teeth Clenching/Grinding

Authorization and Release:

I certify that I have read and answered the above information to the best of my knowledge and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes in my medical or dental history I will so inform this practice.

Signature: X ____ Date: ____________

Rev. 8/5/15

Patient Name: ____

Medical History: For any of those below to which you answer yes, PLEASE LIST.

Physician's Name: ____

Yes No Taking any medications/supplements / herbals? List:____________________
Yes No Allergic to any medication/foods/latex/metals/acrylics/anesthetics/ etc? List:____________________
Yes No Had a history of a major illness? List:____________________
Yes No Had any major operations? List:____________________
Yes No Ever been involved in a serious accident? Details:____________________
Yes No Ever taken bisphosphonates for osteoporosis or other bone diseases? List:____________________
Yes No Chews or smokes tobacco products? If so, how long? ____________________
Yes No Is the patient pregnant? If yes, please list due date:____________________
Yes No Have or had a substance abuse problem?
Yes No Requires antibiotics be taken prior to dental procedures?

Check any of the medical conditions below that the patient has or has had:

☐Tumor or Cancer
☐Tuberculosis
☐Rheumatic Fever
☐Radiation / Chemo
☐Diabetes Type _____
☐Congenital Heart Defect
☐Bone Disorders
☐Pneumonia
☐Kidney Problems
☐HIV/AIDS
☐High Blood Pressures
☐Herpes
☐Hepatitis Type _____
☐Asthma
☐Hay fever
☐Arthritis
☐Anemia
☐Bleeding/Hemophilia
☐Heart Murmur
☐Gastrointestinal Disorders
☐Nervous Disorders
☐Heart Problem
☐Epilepsy
☐Dizziness

Any conditions/illnesses or hospitalizations not listed above: ____________________

Dental History:

Dentist's Name: ____________________ Date of Last Exam/Cleaning: ____________

Yes No Did your general dentist refer your child for this consultation? If Yes, please describe the dentist's orthodontic concerns: ____________________
Yes No Does your child have any dental work recommended by the dentist that has not yet been completed? If Yes, circle all that apply: Cleaning, Filling, Crown, Bridge, Implant, Extraction, Other: ____________________
Yes No Has the patient had an adverse reaction to any dental procedure? Details: ____________________
Yes No Has the patient received orthodontic treatment in the past? Describe:____________________
Yes No Have you visited another orthodontist for a new patient exam/consultation? Dr. Name?____________________
What are you hoping for orthodontics to correct? ____________________

Check any of the dental conditions below that apply to this patient's dental history:

☐Bad Breath
☐Chipped Tooth/Teeth
☐Dental Pain
☐Extraction of Baby Teeth
☐Extraction of Adult Teeth
☐Gum Bleeding
☐Gum Inflammation
☐Gum Recession
☐Finger/Thumb Sucking
☐Tongue Thrust
☐ Lip Sucking/Biting
☐Strong Gag Reflex
☐Head/Facial Injury
☐Mouth/Chin/Jaw Injury
☐Teeth Injury
☐Jaw Clicking/Popping
☐Jaw Pain
☐Mouth Breather
☐Pressure Sensitivity
☐Temperature Sensitivity
☐Teeth Clenching/Grinding
☐Jaw Locking
☐Snoring

Authorization and Release:

I certify that I have read and answered the above information to the best of my knowledge and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes in my medical or dental history I will so inform this practice.

Signature: X ______________________________ Date: ______________

Dental Insurance Information Form

This form is for DENTAL coverage only. The information you provide will be used to verify your orthodontic benefit, so please fill out this form completely. As a courtesy, we are happy to file an insurance claim on your behalf once active treatment is initiated. Without this information we are unable to file your claim.

Patient Name:______________________________ Patient's DOB:______________________

Primary Insurance Co Name:_________________________ Phone #____________________

Insurance Co. Address: _____________________ City __________ State________ Zip__________

Subscriber's Name: _____________________Relationship to Patient:___________ DOB:__________

Subscriber's Address: ______________________ City__________ State________ Zip___________

Social Security # __________________ Subscriber ID #__________________ Group #___________

Employer:____________________________________ Work Phone # _______________________

Secondary Insurance Co Name:_________________________ Phone #___________________

Insurance Co. Address: _____________________ City __________ State________ Zip__________

Subscriber's Name: _____________________Relationship to Patient:___________ DOB:__________

Subscriber's Address: ______________________ City__________ State________ Zip___________

Social Security # __________________ Subscriber ID #__________________ Group #___________

Employer:____________________________________ Work Phone # _______________________

OFFICE USE ONLY

Ins. Co_________________________ Effective Date______________ Waiting Period____________

Deductible_____________ Age Limit______________ Lifetime Benefit_______________________

Has any Benefit Been Used?_____________ Benefit Paid? Monthly Quarterly Annually Other:_________

Automatic? Yes No Benefit Paid to: Subscriber Provider Percent Paid At Start ______

Ins. Co_________________________ Effective Date______________ Waiting Period____________

Deductible_____________ Age Limit______________ Lifetime Benefit_______________________

Has any Benefit Been Used?_____________ Benefit Paid? Monthly Quarterly Annually Other:_________

Automatic? Yes No Benefit Paid to: Subscriber Provider Percent Paid At Start ______

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.)
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.)
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation
- Internally, to all staff members who have any role in your treatment
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment.
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information
- Request confidential communication of your protected health information
- Inspect and obtain copies of your protected health information through asking us
- Amend or modify your protected health information in certain circumstances
- Receive an accounting of certain disclosures made by us of your protected health information
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us(by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information
- To abide by the terms of our Privacy Notice that is currently in effect
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information
- Amend your protected health information if, for example, it is accurate and complete
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient Name:____

Signature: X____ Date: ____________________