



Date: _____

Patient ID # _____

Patient Information

First Name	Last Name	Name to be called	Date of Birth	Age	Sex
Street Address where patient resides (Please no PO Box)		City	State	Zip	
Best Contact Number	Type (Circle One) Home Cell	Cell Phone Service Provider	Best Contact Email Address		
Patient's School			Grade		
Please list all siblings and their age					
Relatives who are (were) patients of Smithfield Orthodontics			How did you hear about our office?		
In case of emergency please notify	Relationship to Patient	Phone No.	Patient's Hobbies/ Special Interests		

Parent/Guardian Information

Patient lives with:			Relationship
Parent's Marital Status			
Mother's Name	Date of Birth	Email Address	Social Security #
Address			
Home Phone	Work Phone	Cell Phone	
Employer	Position	How Long?	
Father's Name	Date of Birth	Email Address	Social Security #
Address			
Home Phone	Work Phone	Cell Phone	
Employer	Position	How Long?	
Step-parent/Guardian's Name	Date of Birth	Email Address	Social Security #
Address			
Home Phone	Work Phone	Cell Phone	
Employer	Position	How Long?	
Step-parent/Guardian's Name	Date of Birth	Email Address	Social Security #
Address			
Home Phone	Work Phone	Cell Phone	
Employer	Position	How Long?	

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



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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Tumor or Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Bleeding/Hemophilia |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressures | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Radiation / Chemo | <input type="checkbox"/> Herpes | <input type="checkbox"/> Gastrointestinal Disorders |
| <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> 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:

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

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: _____