PENDLETON orthodontics

New Adult Patient Information

Patient Name: _____
Last First Middle Likes to be called

Home Address: _____
Street City State Zip

Date of Birth: _____ Age: _____ Sex: _____ Email: _____

Phone: _____ Occupation: _____ Company Name: _____

Work Phone: _____ Other phone: _____

Dentist: _____ Referred to us by: _____

Marital Status: Married Separated Divorced Remarried Widowed Name and Age of any children

in the family: _____ Spouse or Partner's Name:

_____ Employment: _____ List Interests/ Sports/

Hobbies: _____ Favorite TV/Movie:

_____ Favorite Music: _____ **Do you have**

dental insurance coverage? Yes No

Dental Insurance Company: _____ Contact #: _____

Insurance Claims Address: _____
Street City State Zip

Subscriber Name: _____ Date of Birth: _____

Subscriber SSN: _____ Subscriber ID #: _____ Group #: _____

PENDLETON orthodontics

Medical History

For the following questions mark yes, no or don't know/understand (DK/U). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile:

Yes No DK/U

- Does patient follow directions well?
- Does the patient brush their teeth conscientiously?
- Does the patient have learning disabilities or need extra help with instruction? Is the patient self conscience or sensitive about their teeth?
- Does the patient have any sensory issues?

Medical History: Now or in the past, has the patient had any of the following:

Yes No DK/U

- Birth defects or heredity problems
- Bone fractures, any major accident
- Rheumatoid or arthritic conditions
- Endocrine or thyroid problems
- Kidney problems
- Diabetes
- Cancer, tumor radiation or chemotherapy
- Stomach ulcer or hyperacidity
- AIDS or HIV positive
- Hepatitis, jaundice or liver problems
- Fainting spells,seizures, epilepsy or neurological problems
- Mental health disturbance or depression
- Vision, hearing, taste or speech difficulties
- Loss of weight recently, or poor appetite
- History of eating disorder
- Excessive bruising, anemia or bleeding disorder
- High or low blood pressure
- Cardiovascular problems
- Skin disorder
- Frequent headaches, colds or sore throat
- Ear, nose or throat condition
- Hayfever, asthma, sinus trouble or hives
- Tonsil or adenoid conditions

Allergies or reactions to any of the following:

Yes No DK/U

- Local anesthetics (Novocaine or Lidocaine)
- Aspirin
- Ibuprofen (Motrin, Advil)
- Penicillin or other antibiotics
- Sulfa drugs
- Codeine or other narcotics
- Metals (jewelry, clothing snaps)
- Latex (gloves, balloons)
- Vinyl
- Acrylic
- Animals
- Foods (specify) _____
- Other substances (specify) _____
- Does the patient currently have or ever had a substance abuse problem? Does the patient chew or smoke tobacco?
- Is the patient taking medication, nutrient supplements, Herbal medications or non-prescription medicine? Please name them:

Medication _____ Taken for:_____ Medication_____ Taken for:_____

Operations? Describe: _____ Hospitalized for?: _____

Other physical problems or symptoms? Describe:_____

Being treated by another health care professional? For: _____

Date of most recent physical exam? _____

Are there any other medical conditions that we should be made aware of?_____

Girls only:

- Has the patient started her monthly periods? If so,approximately when? _____
- Is the patient pregnant? _____

Family Medical History:

Do your parents or siblings have any of the following health problems? If so, please explain: Bleeding disorders Unusual dental problems Diabetes Arthritis Jaw size imbalance Severe allergies

_____

Any other family medical conditions that we should know about?_____

PENDLETON orthodontics

Dental History

Now or in the past, has the patient had:

Yes No DK/U

- Started teething very early or late
- Primary (baby) teeth removed that were not loose
- Permanent or “extra” (supernumerary) teeth removed
- Supernumerary (extra) or congenitally missing teeth
- Chipped or otherwise injured primary (baby) or permanent teeth
- Teeth sensitive to hot or cold; teeth throb or ache
- Jaw fractures, cysts or mouth infections
- “Dead teeth” or root canals treated
- Bleeding gums, bad taste or odor in the mouth
- Periodontal “gum problems”
- Food impaction between teeth
- Thumb, finger or sucking habit Until what age? _____
- Abnormal swallowing habit (tongue thrusting)
- History of speech problems
- Mouth breathing habit, snoring or difficulty in breathing
- Tooth grinding or jaw clenching
- Any pain in jaw or ringing in the ears
- Any pain or soreness in the muscles of the face or around the ears
- Difficulty in chewing or jaw opening
- Aware of loose, broken or missing restoration (fillings)
- Any teeth irritating cheek, lip, tongue or palate
- Concerned about spaced, crooked or protruding teeth
- Aware or concerned about under or over developed jaw
- “Gum boils”, frequent canker sores or cold sores
- Taking any forms of fluoride
- Had periodontal (gum) treatment
- Would the patient object to wearing orthodontic appliances (braces) should they be indicated? Any serious trouble associated with any previous dental treatment
- Ever had a prior orthodontic examination or treatment
- Been under another dentist’s care? Specialist: _____ Other: _____ How often does your child brush: _____ Floss: _____

What is your primary concern: _____

Why is your child here? _____

How did you hear about us? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so infor this practice.

Signed: _____ Date signed: _____
Patient/Responsible Party

Signed: _____ Date signed: _____
Dental staff member

Notice of Privacy Practices

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use the form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

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 in connection with your treatment, payment of your account or health care operations (i.e. performance reviews, certification, accreditation and licensure).

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's signature: _____ Date: _____

Print Name: _____

Responsible Party (if not patient): _____ Date: _____

Print Name: _____ Relationship to patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement An emergency

situation prevented us from obtaining acknowledgement Other (please specify):

_____