Sample Orthodontics
History Form for Adults

For Office Use Only		
Update #1 ____________	Date	Team Member
Update #2____________	Date	Team Member

Today's Date: ______________________

Patient Information:

Patient's Name: ____________________________________ Prefers to be called: ____________________

Birth Date: ____________________________ Gender: ( ) Female ( ) Male

Social Security # ________ - _______ - _______

Home Address: ____

City: ______________ State: _________ Zip Code: ________________

Home Phone: _________________________ Cell Phone: ___________________________

Email Address: _____________________________________ Employer: _____________________________

Who can we thank for referring you to our office? ____

General Orthodontic Information:

What concerns do you have about your teeth? _______________________________________

Have you seen an orthodontist before? ………………………………………………………………………………. ( ) Yes ( ) No

Have you undergone orthodontic treatment before? ……………………………………………………………………… ( ) Yes ( ) No

- If so, what treatment was performed? _______________________

Have other family members been treated in our office? Please name them: ____

General Dental History:

(all answers are confidential. A thorough dental history is often needed for orthodontic diagnosis and treatment planning)

Patient's Dentist: _______________________________

Do you see your dentist regularly? ……………………………………………………………………………………………… ( ) Yes ( ) No.

- Last visit (approximate): Month ______________ Year ______________

Are you currently under the care of another dental specialist (periodontist, endodontist, oral surgeon)? ( ) Yes ( ) No.

- If so, who?_______________________

Do you have any symptoms of temporomandibular joint (TMJ) disorder? ………………………………………. ( ) Yes ( ) No

- Tooth grinding/clenching? …………………………………………………………………………………………………… ( ) Yes ( ) No
- Locking or feeling "stuck" during opening/closing? ……………………………………………………………… ( ) Yes ( ) No.
  - If so, which side? ( ) Right ( ) Left
- Clicking or popping in the jaw joint? …………………………………………………………………………………… ( ) Yes ( ) No.
  - If so, which side? ( ) Right ( ) Left.

Do you have any gum problems or been diagnosed with gum or periodontal disease (pyorrhea)?......... ( ) Yes ( ) No.

Have you had any injuries to the face, mouth, or teeth?.. ( ) Yes ( ) No.

- If yes, please explain: ____

Are you missing any permanent teeth, or have any permanent teeth been extracted?........................ ( ) Yes ( ) No.

General Medical History:

(all answers are confidential. A thorough medical history is often needed for orthodontic diagnosis and treatment planning)

Physician: ________________________________

Do you take antibiotics before dental treatment due to a medical issue? ………………………………………. ( ) Yes ( ) No

Do you have any allergies to

- Latex? ……………………………………………… ( ) Yes ( ) No.
- Nickel or other metals? ……………………. ( ) Yes ( ) No
- Medications? ……………………………………. ( ) Yes ( ) No If yes, which medications: ____________________
- Any other allergies (ie food, environment). ( ) Yes ( ) No If yes, what: ______________________________

Please list medications currently being taken:

- __________________________________ Reason: _________________________________
- __________________________________ Reason: _________________________________
- __________________________________ Reason: _________________________________

Now or in the past, have you had:

Emotional, sensory or developmental issues? ( ) Yes ( ) No
Speech problems? ( ) Yes ( ) No
Hereditary or developmental conditions? ( ) Yes ( ) No
Bone fractures, or major injuries? ( ) Yes ( ) No
Any injuries to head, neck? ( ) Yes ( ) No
Arthritis or joint problems? ( ) Yes ( ) No
Cancer, tumor, radiation, or chemotherapy? ( ) Yes ( ) No
Endocrine, hormone or thyroid problems? ( ) Yes ( ) No
Diabetes or low blood sugar? ( ) Yes ( ) No
Kidney problems? ( ) Yes ( ) No
Immune system problems? ( ) Yes ( ) No
History of osteoporosis? ( ) Yes ( ) No
Sexually transmitted diseases? ( ) Yes ( ) No
AIDS or HIV positive? ( ) Yes ( ) No
Hepatitis, jaundice, or other liver problems? ( ) Yes ( ) No
Polio, mononucleosis, tuberculosis, pneumonia? ( ) Yes ( ) No
Seizures, fainting spells, neurologic problem? ( ) Yes ( ) No
Mental health disturbance or depression? ( ) Yes ( ) No
Eating disorder (anorexia, bulimia)? ( ) Yes ( ) No
Frequent headaches or migraines? ( ) Yes ( ) No
High or low blood pressure? ( ) Yes ( ) No

Excessive bleeding or bruising, anemia? ( ) Yes ( ) No
Any heart or cardiovascular problems? ( ) Yes ( ) No
Heart murmur, rheumatic heart disease? ( ) Yes ( ) No
Skin disorders (other than common acne)? ( ) Yes ( ) No
Vision, hearing, or speech problems? ( ) Yes ( ) No
Frequent ear infections, throat infections? ( ) Yes ( ) No
Asthma, sinus problems, hayfever? ( ) Yes ( ) No
Tonsil or adenoids removed? ( ) Yes ( ) No
Does your child frequently breathe through his/her mouth because of nasal obstruction? ( ) Yes ( ) No

Has your child ever taken intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)? ( ) Yes ( ) No

Has your child ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) ? ( ) Yes ( ) No

Please explain any "yes" answers: ____

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Females, are you pregnant? ( ) Yes ( ) No

Family Information:

Spouse (or Closest Living Relative): ____________________________ Employer: ____

Address (if different): ______________________________ City: _______________ State: _______ Zip Code: _______________

Home Phone: __________________________ Cell Phone: _____________________________

Email Address: ____

Financial Responsibility:

Who is financially responsible for this account? ________________________________

Address (*if different from above*): ______________________________________

City: _______________ State: _________ Zip Code: _________________

Home Phone: __________________________ Cell Phone: ____________________________

Email Address: ____

Social Security # _____________________________ Employer: ______________________________

Dental Insurance:

Primary Policy Holder's full name: ________________________________ Birth Date: _______________________

Social Security # _______________________________ Relationship to the Patient: ______________________

Address & Phone# (*if not listed above*): ____

Employer: ____

Insurance Company: _______________________________________

Group #: _____________________________________ Policy #: _______________________________________

Secondary Policy Holder's full name: ________________________________ Birth Date: _______________________

Social Security # _______________________________ Relationship to the Patient: ______________________

Address & Phone# (*if not listed above*): ____

Employer: ____

Insurance Company: _______________________________________

Group #: _____________________________________ Policy #: _______________________________________

Releases and Waivers

I authorize release of any information regarding my orthodontic treatment to my dental insurance company. ( ) Yes ( ) No

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her team responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health. ( ) Yes ( ) No

Our office uses email and standard SMS messaging to update patients and/or parents about appointments, treatment progress, and billing. I hereby consent and state my preference to have Dr. Sample and other team members at Sample Orthodontics communicate with me by email or standard SMS messaging regarding various aspects of my dental care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. Additionally, I understand that any of the phone numbers provided may be used for these communication purposes. ( ) Yes ( ) No

I acknowledge receipt of the Notice of Privacy Practices which detail how Protected Health Information may be Used and disclosed, and how I may access that information. ( ) Yes ( ) No

____ ____________________

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

Lew B. Sample, DMD, MS, PC

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATON IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/1/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations for example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for our healthcare but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms or health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contract information listed at the end of this Notice. We will charge you a reasonable cost-based fee for the expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.30 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional request.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of health and Human Services.

Lew B. Sample, DMD, MS, PC
2014 Danville Park Dr. SW
Decatur, AL 35603
256-355-5255

Lew B. Sample, DMD, MS, PC
220 Karl Prince Dr.
Hartselle, AL 35640
256-773-8681