Welcome

Patient # _____

Patient Information *(Confidential)*

Date _____

Name _____ Male____ Female____ Date of Birth ____/____/_____

Parent/Guardian:

Check One:
___Single ___Widow
___Married ___Divorced/ Separated

Name _____ Male____ Female____

Address_____ City _____ State _____ Zip_____

Home Phone (____)_____ Social Security #_____

Cell Phone (____)_____ E-Mail Address _____

Please let us know if you authorize us to send text messages to cell phone: Check one: Yes:_____ / No:_____

Parent's Employer _____ Work Phone (____)_____

Business Address_____ City _____ State _____ Zip _____

If Patient is a Full-Time College Student, Name of College _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Were you or your dependent a Patient in Our Office: ☐ Yes ☐No

Responsible Party (if Parent/Guardian, above than leave blank)

Name of Person Responsible for this Account _____ Relationship to Patient: _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Social Security # _____

DENTAL INSURANCE INFORMATION - ONLY

Name of Insured _____ Phone_____

Address of Insured_____ Relationship to Patient:_____

Social Security # _____ ID# _____ Date of Birth _____

Name/Address of Employer_____

Name of Insurance Company _____ Phone # (___)_____

Have you previously used any of your Ortho Benefits ☐Yes ☐No

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE - Only ☐ YES ☐ NO - IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Phone_____

Address of Insured_____ Relationship to Patient:_____

Social Security # _____ ID#_____ Date of Birth _____

Name / Address of Employer_____

Name of Insurance Company _____ Phone # (____) _____

Have you Previously Used Any of Your Ortho Benefits ☐ Yes ☐ No

Medical/Dental History

Name of Your Physician _____ Phone # (___)_____

Date of Last Physical _____ If patient is a minor, is she/he adopted? _____

Please Answer the Following:

	Yes	No
1. Are you currently under medical treatment	☐	☐
2. Have you ever been hospitalized for any surgical operations or serious illness?	☐	☐
3. Are you taking any medication (s) including non- prescription medicine? If Yes, What medications are you taking? _____	☐	☐
4. Do you use tobacco?	☐	☐
5a. Do you use alcohol?	☐	☐
5b. Do you use cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have any reactions to the following?	Yes	No
Local Anesthetic (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. WOMEN ONLY:	Yes	No
a) Are You Pregnant?	☐	☐
b) Are You Nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

9. Do you have or have you ever had any of the following?

	Yes/	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Hepatitis/Jaundice	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Respiratory Problems	☐	☐	Stomach Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted			Other	☐	☐
Thyroid Problems	☐	☐	Disease	☐	☐	_____		

Name of Your General Dentist _____ Phone(___)_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids?	☐	☐
3. Are your teeth sensitive to sweet or sour foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw pain?	☐	☐
7. Have you ever experienced any of the following?	☐	☐
a) Clicking	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐

General Information

1. Does anyone in your family have a similar dental or facial condition? If yes, explain_____

_____

2. Have any other members of your family received orthodontic treatment? Yes ☐ No ☐

3. When did you last receive dental care? _____

4. How frequently do you brush your teeth? _____

5. Do you have any of the following habits?

lip sucking	☐	thumb or finger sucking	☐
lip biting	☐	nail biting	☐
tooth grinding	☐	tongue thrusting	☐
constant mouth breathing	☐		

6. Please express any concerns you may have concerning orthodontic treatment. _____

_____

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers or to health care practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ Date_____

(Patient or Parent if Patient is a Minor)

David J. Stevens, DDS, PC

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PATIENT CONSENT FORM

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is kept private. This role was also established in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care operations.

We want you to know that we respect the privacy of your personal medical records and will lake all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only-those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose PHI for purposes of treatment, payment, and/or other health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have tile right to refuse to consent to the use or disclosure of your PHI. This refusal must be made in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. If you give consent to disclose your PHI, by signing this document, you can at some future time request to refuse future disclosures of your PHI. This refusal must be made in writing.
However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our Compliance Officer if you have any objections to this consent.

_____ _____

Signature: Print Name **Date**