ADULT PATIENT INFORMATION

Date_____

Patient Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____
(Must list 2 phone numbers)

Email Address _____ Date of Birth _____ Social Security # _____

Employer _____ Occupation _____ Years Employed _____

Marital Status: Single ___ Married ___ Widowed___ Separated___ Divorced___

Spouse's Name _____ Date of Birth _____Social Security #_____

Employer _____ Occupation _____ Years Employed _____

Work Phone _____ Cell Phone _____ Email Address _____

Whom may we thank for referring you to our office?_____

Do you know anyone who may benefit from our services?_____

Primary Dental Insurance Information

Name of Insured_____ Relationship to patient_____ Date of Birth_____

Insured's Social Security#_____ Insurance Company_____ Group#_____

Identification#_____ Insurance Phone#_____ Employer Name_____

Claims mailing Address _____

Secondary Dental Insurance

(Our office only files with Primary Insurance)

Name of Insured_____ Relationship to patient_____ Date of Birth_____

Insured's Social Security#_____ Insurance Company_____ Group#_____

Identification#_____ Insurance Phone#_____ Employer Name_____

Claims mailing Address _____

Emergency Information

Name of nearest relative not living with you_____ Relationship to patient _____

Complete address_____

Phone_____

I understand that, where appropriate, credit bureau reports may be obtained.

I confirm that the information above is complete and truthful to the best of my knowledge.

Signature of patient _____ Date_____

Updates (date & initial) _____

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for a gorgeous smile...

Dental and Medical History

Dental History

Dentist Name_____ Last Visit _____Last Cleaning_____

Has the treatment plan suggested by the patient's general dentist been finished? Yes No

Has the patient had any tenderness or pain in the jaw joint? Yes No

Do the patient's gums bleed? Yes No

Does the patient have any of the following habits?

Sucks his/her nails? Yes No Sucks his/her lips? Yes No Bites his/her nails? Yes No

Have tongue thrusting habit? Yes No Sucks his/her thumb/finger? Yes No

What is your primary reason for wanting Orthodontic Treatment? _____

Have you seen any other Orthodontists for this reason? Yes No When?_____

Medical History

How is the patient's general health? Excellent Good Fair Poor

Is there anything in the patient's medical history that we should be aware of? Yes No

If yes, Explain?_____

Name of patient's physician_____ Phone number_____

Is the patient taking any medication Yes No Name/Dosage _____

Does the patient smoke ? Yes No

Is the patient pregnant? Yes No If yes, what week?_____

Is the patient allergic to any of the following?

Dental anesthetics:	Yes	No	Codeine:	Yes	No
Penicillin:	Yes	No	Erythromycin:	Yes	No
Aspirin:	Yes	No	Latex:	Yes	No
Tetracycline:	Yes	No	Other: _____		

Has the patient ever had any of the following conditions?

Heart Attack	Yes	No	Congenital Heart Def.	Yes	No	Prosthesis	Yes	No
Cancer	Yes	No	Diabetes	Yes	No	Rheumatic Fever	Yes	No
Hemophilia	Yes	No	Shingles	Yes	No	Fever Blisters	Yes	No
Tuberculosis	Yes	No	Ulcers/Colitis	Yes	No	Drug/Alc. Abuse	Yes	No
Scarlet Fever	Yes	No	Convulsions	Yes	No	Abnormal Bleeding	Yes	No
Anemia	Yes	No	Radiation Treatment	Yes	No	Heart Surgery	Yes	No
Pacemaker	Yes	No	Kidney/Liver Problem	Yes	No	Hospital Stays	Yes	No
Emphysema	Yes	No	Mitral Valve prolapsed	Yes	No	Glaucoma	Yes	No
Asthma	Yes	No	Artificial bones/joints	Yes	No	Sinus Problems	Yes	No
Artificial Valves	Yes	No	Severe/Freq. Headaches	Yes	No	Difficulty Breathing	Yes	No
Blood transfusion	Yes	No	Venereal Disease	Yes	No	Heart Murmur	Yes	No
Hepatitis A or B	Yes	No	HIV and/or AIDs	Yes	No	Other _____		

Referral: How did you hear about us?

Doctor Dentist Other Patient Insurance Internet Magazine Website Staff

PRIVACY NOTICE AND AUTHORIZATION

"Patient's rights and responsibilities"

Dr. Yesenia Garcia and or GORTHODONTICS is a covered entity under HIPAA, the Health Insurance Portability and Accountability Act of 1996, with respect to the operation of our office. These Privacy and Security Rules restrict our ability to use and disclose your protected health information ("PHI").

Your protected health information (PHI) such as your name, date of birth, dates of treatment, phone/fax numbers, email address, home address, social security number, other demographic data, as well as information pertaining to your diagnosis and treatment, may only be disclosed by administrative personnel, the teaching staff, dental assistants, and students, and can only be used or disclosed for::

- Contacting other health care providers (i.e., general dentist, oral surgeon, pediatrician, etc.) in connection with our rendering orthodontic treatment to you/your child;
- Contacting third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment on your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and/or accrediting bodies (i.e., State Dental Boards, American Board of Orthodontics, etc.,) in order to obtain certification, licensure or accreditation;
- To various courts, for use in legal actions of any type, upon your authorization or upon subpoena;
- Internally, to all staff members who have any role in your treatment or to laboratories who render supportive services (i.e.; labs that make retainers or models, etc.);
- To other patients and third parties who may inadvertently see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family or close friends who may be involved in your treatment;
- To provide you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you; and/or,
- Practice and/or marketing promotions; and
- For use in scientific lectures, publications, presentations, continuing dental educational courses.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which will not expire and which you have the right to revoke at any time upon proper notification, however any revocation will not be retroactive.

Under these 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 from us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your PHI; and,
- You may, without risk of retaliation, file a complaint with us concerning any violation of your privacy rights by submitting inquiries to the office.

  Official to our office address in writing or to the United States Secretary of Health and Human Services in Washington D.C. within 180 days of the violation.

We have the following duties under the new privacy rules:

- To maintain the privacy of your PHI 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 this Privacy Notice and to make new notice provisions effective for all PHI maintained by us and if we do so, to give 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 PHI;
- Amend your PHI if it is accurate and complete; or,
- 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.
- Protect against re-disclosure of your PHI by those legally entitled to receive it from us

This privacy notice is effective as of the date of your signature. If you have any questions about this Notice, please ask for our Privacy Contact Officer or contact him/her at our office address. Thank you.

PATIENT / PARENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice; or, alternatively, I have refused to review it.

_____ _____

Patient or parent/guardian if patient is a minor Date

_____ _____

Witness Date

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ORTHODONTIC INFORMED CONSENT

During Bisphosphonate Treatment

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for the Orthodontic Patient

Risks and Limitations of Orthodontic Treatment

The purpose of this document is to inform you of the general risks associated with orthodontic treatment of patients who are now taking, or have taken in the past, medications known as "bisphosphonates." Bisphosphonates are medications prescribed by your physician for the treatment of a variety of difficult medical disorders. Bisphosphonate medication types that you may be taking, or have taken, can be: **Fosamax** (alendronate), **Actonel** (risedronate), **Boniva** (ibandronate), **Skelid** (tiludronate), **Didronel** (etidronate), **Aredia** (pamidronate), or **Zometa** (zoledronic acid). There may be some additional brand names in addition to the above, but they are all known as "bisphosphonates." Every medication has risks and benefits.

All bisphosphonates inhibit osteoclastic (related to bone) activity. They have the ability to, and probably will, inhibit tooth movement during orthodontics. This issue may slow your response to orthodontic movement and lengthen orthodontic treatment time. The effects of these medications may be severe enough to stop tooth movement, which may cause braces to be removed regardless of favorable or unfavorable tooth position. No orthodontist can predict the effect bisphosphonates will have upon an individual's tooth movement.

Long-term bisphosphonate use has been observed to decrease bone healing. It is possible that tooth movement and any surgery procedures performed within the jaws or bone surrounding the teeth may be difficult, and, in some cases, no bone healing may occur.

The risk for developing osteonecrosis is higher for cancer patients on i.v. bisphosphonate therapy.

I have reviewed this notice, and I understand the issues it describes. I have discussed any questions I have with my doctor. I acknowledge I assume these risks and choose to continue with treatment.

Signature of Patient/Parent/Guardian _____ Date _____

American Association of **Orthodontists**