NEW PATIENT FORM (ADULT)

How did you hear about us? _____

What is the most important thing you would like for us to fix? _____

Appointment Reminder Preference: ❑ Text ❑ Phone Call ❑ Email (Email Address:)_____

Patient Name (First, Middle Initial, Last): _____

Birth Date: _____ Age: _____ **Sex: Male ❑ Female ❑**

S.S.N.: _____ **Home Phone No.: _____**

Patient's Address: _____

City: _____ **State: _____ Zip/Postal Code: _____**

Occupation: _____ **Employer: _____Years with employer: _____**

Business Phone No: _____

Name of Spouse/Closest Relative: _____ **Relationship to you: _____**

Spouse/Relative Contact #: _____

Dentist Name: _____ **Phone: _____**

Address: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security#: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security#: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: _____

MEDICAL HISTORY: Now or in the past, have you had:

❑ Yes	❑ No	Birth defects or hereditary problems?
❑ Yes	❑ No	Bone fractures, any major accidents?
❑ Yes	❑ No	Rheumatoid or arthritic conditions?
❑ Yes	❑ No	Endocrine or thyroid problems?
❑ Yes	❑ No	Kidney problems?
❑ Yes	❑ No	Diabetes?
❑ Yes	❑ No	Cancer, tumor, radiation treatment or chemotherapy?
❑ Yes	❑ No	Stomach ulcer or hyperacidity?
❑ Yes	❑ No	Polio, mononucleosis, tuberculosis or pneumonia?
❑ Yes	❑ No	Problems of the immune system?
❑ Yes	❑ No	AIDS or HIV positive?
❑ Yes	❑ No	Hepatitis, jaundice or liver problems?
❑ Yes	❑ No	Fainting spells, seizures, epilepsy or neurological problem?
❑ Yes	❑ No	Mental health disturbance of behavioral problem?
❑ Yes	❑ No	Vision, hearing, tasting or speech difficulties?
❑ Yes	❑ No	Loss of weight recently, poor appetite?
❑ Yes	❑ No	History of eating disorder (anorexia, bulimia)?
❑ Yes	❑ No	Bleeding disorder, bruising tendency, excessive bleeding or anemia?
❑ Yes	❑ No	High or low blood pressure?
❑ Yes	❑ No	Tires easily?
❑ Yes	❑ No	Chest pain, shortness of breath or swelling ankles?
❑ Yes	❑ No	Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
❑ Yes	❑ No	Skin disorder?
❑ Yes	❑ No	Do you eat a well-balanced diet?
❑ Yes	❑ No	Frequent headaches, colds or sore throats?
❑ Yes	❑ No	Eye, ear, nose or throat condition?
❑ Yes	❑ No	Hayfever, asthma, sinus trouble or hives.
❑ Yes	❑ No	Tonsil or adenoid conditions?
❑ Yes	❑ No	Osteporosis?

WOMEN ONLY

❑ Yes	❑ No	Are you pregnant?
❑ Yes	❑ No	Are you anticipating becoming pregnant?

Allergies or reactions to any of the following:

❑ Yes	❑ No	Local anesthetics (Novocaine or Lidocaine)?
❑ Yes	❑ No	Aspirin?
❑ Yes	❑ No	Ibuprofen (Motrin, Advil)?
❑ Yes	❑ No	Penicillin or other antibiotics?
❑ Yes	❑ No	Sulfa drugs?
❑ Yes	❑ No	Codeine or narcotics?
❑ Yes	❑ No	Metals (jewelry, clothing snaps)?
❑ Yes	❑ No	Latex (gloves, balloons)?
❑ Yes	❑ No	Vinyl?
❑ Yes	❑ No	Acrylic?
❑ Yes	❑ No	Animals?
❑ Yes	❑ No	Foods (specify)? _____
❑ Yes	❑ No	Other substances (specify)? _____
		_____

❑ Yes	❑ No	Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

❑ Yes	❑ No	Do you currently have or ever had a substance abuse problem?
❑ Yes	❑ No	Do you chew or smoke tobacco?
❑ Yes	❑ No	Operations? (specify) _____
❑ Yes	❑ No	Hospitalized? (for) _____
❑ Yes	❑ No	Other physical problem or symptoms? (describe) _____
❑ Yes	❑ No	Being treated by another health care professional? (for) _____
		Date of most recent physical exam: _____
❑ Yes	❑ No	Are there any other medical conditions that we should be aware of?
		_____

I have read and understand the above questions. I will not hold my orthodontist or any staff member 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 inform this practice.

Signed: _____ Date signed: _____
(Patient)

Signed: _____ Date signed: _____
(Dental Staff Member)

DENTAL HISTORY: Now or in the past, have you had:

❑ Yes	❑ No	Would you object to wear orthodontic appliances (braces) should they be indicated?
❑ Yes	❑ No	Concerns about your profile?
❑ Yes	❑ No	Concerns about spaced, crooked or protruding teeth?
❑ Yes	❑ No	Aware or concerned about under or over developed jaw?
❑ Yes	❑ No	Any relative with similar tooth or jaw relationships?
❑ Yes	❑ No	Have teeth grown-in quickly or slowly?
❑ Yes	❑ No	Thumb, finger or sucking habit? Until what age? _____
❑ Yes	❑ No	Abnormal swallowing or tongue thrust habit?
❑ Yes	❑ No	History of speech problems?
❑ Yes	❑ No	Mouth breathing, snoring or difficulty in breathing?
❑ Yes	❑ No	Had periodontal (gum) treatment?

❑ Yes	❑ No	Permanent or "extra" (supernumerary) teeth removed?
❑ Yes	❑ No	Chipped teeth or other wise injured teeth?
❑ Yes	❑ No	Teeth sensitive to hot or cold; throb or ache?
❑ Yes	❑ No	Jaw fractures, cysts or mouth infections?
❑ Yes	❑ No	"Dead teeth" or root canals treated?
❑ Yes	❑ No	Food impactions between teeth?
❑ Yes	❑ No	Tooth grinding, jaw clenching, clicking or locking?
❑ Yes	❑ No	Any pain in jaw or ringing in the ears?
❑ Yes	❑ No	Any pain or soreness in the muscles of the face or around the ears?
❑ Yes	❑ No	Difficulty in chewing or jaw opening?
❑ Yes	❑ No	Any loose, broken or missing fillings?
❑ Yes	❑ No	"Gum Boils" canker sores, or cold sores?
❑ Yes	❑ No	Taking any forms of fluoride?
❑ Yes	❑ No	Any serious trouble associated with any previous dental treatment?

❑ Yes ❑ No **Have you ever had an orthodontic examination or received orthodontic treatment before?**

Doctor's name: _____ Date of Exam/Treatment: _____

Reason for not starting treatment with that Doctor?_____

I have read and understand the above questions. I will not hold my orthodontist or any staff member 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 inform this practice.

Signed: _____ Date signed: _____
(Patient)

Signed: _____ Date signed: _____
(Dental Staff Member)

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA):
You may refuse to sign this Acknowledgement. I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____ Signature:_____

Date:_____

Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. “SMS”) or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with *The Brace Place*, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with *The Brace Place*
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don’t want accessing these communications, please talk with *The Brace Place* about ways to keep your communications safe and confidential.

I, _____ authorize The Brace Place at 2630 S. Carrier Pkwy, Grand Prairie TX 75052
(name of patient or guardian)

TO TRANSMIT PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY THE FOLLOWING NON-SECURE MEDIA:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Information concerning my treatment including photos and radiographs.

TERMINATION

This authorization will terminate one month after termination of my orthodontic treatment.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____

Signature of patient or guardian Date

_____ _____

Printed Name of Patient Printed Name of Signer if other than the patient