

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 <input type="checkbox"/> Female <input type="checkbox"/>
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 or behavioral problem?
- Yes No Vision, hearing, tasting or speech difficulties?
- Yes No Have you been diagnosed with sleep apnea?

- Yes No If yes and if a CPAP was recommended are you currently using the CPAP nightly?

- If you are not using a CPAP, our office fabricates appliances for sleep apnea that may be more comfortable. Please speak to our staff if you would like more information.
- 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 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 Osteoporosis?

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/Hospitalizations? (specify) _____
- 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:

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Permanent or "extra" (supernumerary) teeth removed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Teeth sensitive to hot or cold; throb or ache?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw fractures, cysts or mouth infections?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Food impactions between teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tooth grinding, jaw clenching, clicking or locking?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain in jaw or ringing in the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain or soreness in the muscles of the face or around the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty in chewing or jaw opening?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any loose, broken or missing fillings?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Gum Boils" canker sores, or cold sores?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any serious trouble associated with any previous dental treatment?

<input type="checkbox"/> Yes	<input type="checkbox"/> 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. The type of information we may send may include information related to the scheduling of meetings or other appointments, information related to billing and payment, and information concerning my treatment including photos and radiographs.

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 EMAIL, TEXT MESSAGE AND OTHER NON-SECURE MEANS AS DESCRIBED IN OUR COMMUNICATION BY EMAIL, TEXT MESSAGING AND OTHER NON-SECURE MEANS PAPERWORK YOU RECEIVED.

TERMINATION

This authorization will terminate three months 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

Health Information Access

Patient Name: _____

The following names are of people, including myself that I would like to be involved in or have access to the above-mentioned patient's protected health information. I give permission for Dr. Lateefah Washington to share the above-mentioned patient's protected health information with:

Name and Relationship

Name and Relationship

Name and Relationship

Name and Relationship

Patient or Guardian Signature

Date

NOTE: If you wish to add or terminate information access to or from the above list, you must submit your request in writing to our office.