Reopelle ORTHODONTICS

Adult Medical and Dental History

Case _____
Date _____

Patient Information

Last Name _____ First Name _____ Middle Initial _____
Title □ Mr. □ Ms. □ Mrs. □ Dr. Preferred Name _____
□ Female □ Male SSN _____ DOB _____
Address _____ City _____ State _____ Zip Code _____
Phone _____ Email _____
Occupation _____ Employer _____
Emergency Contact _____ Relationship to Patient _____ Phone _____

Financial Responsibility

Who is responsible for this account and relationship to patient? _____

Primary Dental Insurance

Primary Policyholder's Full Name _____ DOB _____ SSN _____
Address and Phone (if not listed above) _____
Relationship to Patient _____
Employer _____ Address _____
Insurance Company _____ Group# _____ ID# _____
Insurance Company's Phone _____ Orthodontic Coverage: □ Yes □ No

I authorize release of any information regarding my treatment to my dental insurance company.

Signature _____ Date _____

Medical History

☐Yes ☐No Are you in good health? Physician _____
Last Seen _____ Phone _____
☐Yes ☐No Any medical specialist(s) being seen now? Reason _____
☐Yes ☐No Have you ever had a health problem? _____
☐Yes ☐No Have you ever been hospitalized? Reasons and dates _____

☐Yes ☐No Medicine or drug allergies? _____ ☐Acrylic ☐Nickel ☐Latex
☐Yes ☐No Are you taking any medications? Provide medication, dose and reason _____

☐Yes ☐No Antibiotic premedication before dental visits?

Please check the box if you have been treated for any of the following:

□ Abnormal Bleeding	□ Autism	□ GI/GERD	□ Rheumatic Fever
□ ADD/ADHD	□ Cancer/Tumors	□ Hearing/Speech	□ Sensory/Behavior
□ Anemia	□ Diabetes	□ Heart Murmur/Disease	□ Seizure(s)
□ Any Operations	□ Endocrine/Growth	□ HIV/AIDS	□ Tuberculosis (TB)
□ Asthma/Breathing	□ Frequent Infections	□ Kidney/Liver	□ Other _____

Explain any checked boxes _____

_____

_____

General Information

What concerns you about your teeth? _____

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

Previous orthodontic consultation? □ Yes □ No; Previous orthodontic treatment? □ Yes □ No

Have any other family members been treated in our office? Name(s) _____

Dental History

Dentist _____ Address _____

Last Seen _____ Reason _____

□ Yes □ No Any dental specialist(s) being seen now? Reason _____

Please check the box if you have been treated for any of the following:

□ Extra or missing teeth	□ Speech concerns/therapy	□ Jaw joint clicking or locking
□ Chipped or injured teeth	□ Mouth breathing or snoring	□ Jaw joint pain
□ Gum disease	□ Tongue thrust	
□ Habits (thumb sucking, etc.)	□ Grinding or clenching	

Explain any checked boxes _____

_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff 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.

Signature _____ Date _____

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Consent for Disclosure of Protected Health Information (HIPAA)

SECTION A: Patient/Parent/Legal Guardian Giving Consent

Patient Name: _____ Date of Birth: _____

SECTION B: Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain, and we will provide you with a copy of the revised Notice of Privacy Practices upon your request.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting it from us.

Reopelle Orthodontics
2114 Colonial Avenue, SW
Roanoke, VA 24015
(540)344-2758

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we will decline to treat you or to continue treating you if you revoke this consent.

I, _____ , have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information or my child's protected health information as described in the "Notice of Privacy Practices."

Signature: _____ **Date:** _____

Relationship to Patient: _____

Other person(s) to whom you give permission to discuss health information or bring child to routine care appointments:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____