**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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

