PATIENT INFORMATION | adult

Date: _____

Patient Name: _____ Gender: ☐ M ☐ F
Last *First* *Middle*

I prefer to be called: _____ Marital Status: _____

Birthdate: _____ Age: _____ Social Security # _____

Mailing Address: _____
Street *City* *State* *Zip Code*

Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____ Years Employed: _____

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

RESPONSIBLE PARTY | if different than patient

Name: _____ Relationship to Patient: _____
Last *First* *Middle*

Address: _____
Street *City* *State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birthdate: _____ Social Security # _____

Employer: _____ Occupation: _____ Years Employed: _____

PRIMARY INSURANCE

Policy Holder Name: _____

SS# _____ Birthdate: _____

Company Name: _____

Group # _____

Member ID # _____

Insurance Phone # _____

SECONDARY INSURANCE

Policy Holder Name: _____

SS# _____ Birthdate: _____

Company Name: _____

Group # _____

Member ID # _____

Insurance Phone # _____

EMERGENCY CONTACT INFORMATION

Name of nearest family member/friend not living with you: _____

Relation: _____ Phone # _____

Address: _____
Street *City* *State* *Zip Code*

TRUMAN
ORTHODONTICS

MEDICAL/DENTAL | history

MEDICAL HISTORY

1. Are you in good health? ☐Y ☐N
2. History of major illness? ☐Y ☐N
   If yes, please list: _____
3. Are there any mental, physical, or social disabilities we should be aware of? ☐Y ☐N
   If yes, please list: _____
4. Are you currently on any medications? ☐Y ☐N
   If yes, please list: _____
5. Are you allergic to any medications or substances including metal? ☐Y ☐N
   If yes, please list: _____
6. Do you use tobacco? ☐Y ☐N
7. Have you ever taken Fosamax (alendronate sodium) or any other medication for osteoporosis? ☐Y ☐N
8. Females only: Are you pregnant, or think you may be? ☐Y ☐N
9. Please check all that apply:

☐ Acid reflux	☐ Cardiac pacemaker	☐ High/Low blood pressure	☐ Respiratory problems
☐ AIDS/HIV	☐ Cold sores	☐ Joint replacement	☐ Rheumatic fever
☐ Allergies/Hay Fever	☐ Diabetes	☐ Kidney/Liver disease	☐ Sinus problems
☐ Anemia	☐ Epilepsy/Seizures	☐ Leukemia	☐ Stroke
☐ Asthma	☐ Fainting	☐ Migraines	☐ Thyroid problems
☐ Bone disorders	☐ Heart problems	☐ Osteoporosis	☐ Tonsil/Adenoid removal
☐ Cancer	☐ Hepatitis	☐ Radiation therapy	☐ Ulcers

DENTAL HISTORY

Dentist: _____ Date of last cleaning: _____

1. Do you get anxious or nervous about dental treatment? ☐Y ☐N
2. Is premedication required before dental work? ☐Y ☐N
3. Any sores or lumps present near mouth? ☐Y ☐N
4. Are there any ongoing jaw problems with:
   Clicking/popping? ☐Y ☐N Pain? ☐Y ☐N Difficulty opening/closing? ☐Y ☐N Difficulty chewing? ☐Y ☐N
5. Do you clench or grind teeth? ☐Y ☐N
6. Do you bite your lips or cheeks frequently? ☐Y ☐N
7. Have you ever had speech therapy? ☐Y ☐N
8. Do you have any of the following oral habits:
   ☐ Mouth breathing ☐ Nail biting ☐ Thumbsucking ☐ Tongue thrust
9. Please check what problems/concerns you are seeking treatment for:
   ☐ Crowding ☐ Missing/Extra teeth ☐ Teeth stick out ☐ TMJ problems
   ☐ Extra space ☐ Poor bite ☐ Teeth erupting in wrong position
   ☐ Other: _____

AUTHORIZATION & RELEASE

_____ Initial
I understand that the information that I have given is correct to the best of my knowledge; that it will be held in strictest of confidence and it is my responsibility to inform this office of any changes. I authorize the dental staff to perform the necessary dental services.

_____ Initial
Truman Orthodontics reserves the right to verify the credit status of potential patients and/or responsible party prior to extending any third-party financing.

_____ Signature

_____ Date

TRUMAN ORTHODONTICS

Patient Acknowledgement of Receipt of Notice of Privacy Practices & Consent/Limited Authorization & Release Form

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Truman Orthodontics. A copy of this signed, dated document shall be as effective as the original. *My signature will also serve as a PHI (Personal Health Information) document release should I request treatment or radiographs be sent to other attending doctors/facilites in the future.*

_____ _____

Please **print** name of patient | Please **sign** for Patient/Guardian of Patient

_____ _____

Legal Representative/ Guardian | Relationship of Legal Representative / Guardian

How do you want to be addressed when being retreived from the reception area?:

☐ First Name Only ☐ First and Last Name ☐ Proper Surname ☐ Other: _____

I authorize contact from this office to *confirm my appointments, treatment & billing information* via:

☐Cell Phone Confirmation _____ ☐Text Message to my Cell Phone _____

☐Home Phone Confirmation _____ ☐Email Confirmation _____

☐Work Phone Confirmation _____ ☐**Any of the above**

I authorize *information about my health* be conveyed via:

☐Cell Phone Confirmation ☐Text Message to my Cell Phone

☐Home Phone Confirmation ☐Email Confirmation

☐Work Phone Confirmation ☐**Any of the above**

I approve being contacted about *special services, events & fund raising efforts or new health info* on behalf of Truman Orthodontics via:

☐ Phone Message ☐**Any of the Above**

☐ Text Message ☐**None of the Above - opt out**

☐Email

By signing below I, _____, give Truman Orthodontics permission to use my intra-oral
Print Patient Name

photographs, facial photographs and xrays in my dental record for continuing education & marketing purposes.

_____ _____

Patient/Guardian Signature | Relationship to patient

In signing the HIPPA Patient Acknowledgement Form, you acknowledge and authorize, that Truman Orthodontics may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

For Office Use Only

As Privacy officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐It was emergency treatment ☐I could not communicate with the patient

☐The patient refused to sign ☐The patient was unable to sign because:

☐Other:

_____ _____

_____ Signature of Privacy Officer