Adult Information Sheet

Dr. ______________________________

PATIENT INFORMATION

Date: ______________________________
Patient's Name: ______________________________
Date of Birth: ______________ Age: ______ Sex: ______
Street Address: ______________________________
City, State, Zip: ______________________________
Home Phone.: ______________________________
Other Phone: ______________________________
E-Mail: ______________________________
Employer: ______________________________
Occupation: ______________________________
Employer Address: ______________________________
Business Phone: ______________________________
Dentist: ______________ Phone No.: ______________
Physician: ______________ Phone No.: ______________

Who may we thank for referring you to our office?

____

Marital Status: ______________________________
Spouse's Name: ______________________________
Date of Birth: ______________ Age: ______ Sex: ______
Employer: ______________________________
Occupation: ______________________________
Employer Address: ______________________________
Business Phone: ______________________________
Person Responsible for Account: ______________________________
Social Security No.: ______________________________
Name and Ages of Children in Family: ______________________________

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INSURANCE INFORMATION

Do you have Orthodontic Insurance coverage? ❑ Yes ❑ No
Name of Insurance Co.: ______________________________
Mailing Address: ______________________________
Phone: ______________________________
City, State, Zip: ______________________________
Policy Holder: ______________________________
Social Security Number: ______________ DOB ______________
Patient ID No.: ______________ Group # ______________
Employer: ______________________________

HEALTH HISTORY

Allergic to Latex .... ❑ Yes ❑ No
Seizures .... ❑ Yes ❑ No
Diabetes .... ❑ Yes ❑ No
Heart Murmur .... ❑ Yes ❑ No
Mitral Valve Prolapse .... ❑ Yes ❑ No
Rheumatic Fever .... ❑ Yes ❑ No
Scarlet Fever .... ❑ Yes ❑ No
Tuberculosis .... ❑ Yes ❑ No
Asthma .... ❑ Yes ❑ No
Heart Trouble .... ❑ Yes ❑ No
Prolonged Bleeding .... ❑ Yes ❑ No
Mental Disorder .... ❑ Yes ❑ No
Attention Deficit Disorder .... ❑ Yes ❑ No
Scoliosis .... ❑ Yes ❑ No
Fainting or Dizziness .... ❑ Yes ❑ No
Cancer .... ❑ Yes ❑ No
Endocrine Problems .... ❑ Yes ❑ No
Blood Disorders .... ❑ Yes ❑ No
Immunosuppressive Disease (HIV) .... ❑ Yes ❑ No
Speech Problems .... ❑ Yes ❑ No
Seasonal Allergies .... ❑ Yes ❑ No
Have tonsils/adenoids been removed? .... ❑ Yes ❑ No
Do you get frequent headaches? .... ❑ Yes ❑ No
Does your jaw ever "pop"? .... ❑ Yes ❑ No
Has your jaw ever "locked"? .... ❑ Yes ❑ No
Is there any other information that may be helpful? ______________

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Have you been advised to pre-medicate? .... ❑ Yes ❑ No
If yes, please explain: ______________________________

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Have there been any injuries to face, mouth or teeth? ❑ Yes ❑ No
If yes, what? ______________________________

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Have you ever been tested or treated for hepatitis? .... ❑ Yes ❑ No
Does the patient play a musical (wind) instrument? .. ❑ Yes ❑ No

***HEALTH HISTORY** (continued)*

Do you see your dentist every six months for cleaning?

❑ Yes ❑ No

How many times a day do you brush? ______________________

How is your health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you under the care of a physician? ❑ Yes ❑ No

If yes, for what reason?___________________________________

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If you are taking medications, please list:___________________

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I authorize release of any information to the insurance company.

____
Signature

I authorize payment directly to Benedict Orthodontics by my insurance company.

____
Signature

I authorize the information to be correct. I understand it is my responsibility to notify Benedict Orthodontics of any changes in my health history.

____
Signature Date

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 before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving this office 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 may decline to treat you or to continue treating you if you revoke this Consent.*

SIGNATURE

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 to carry out treatment, payment activities and health care operations.

____________________________________ ______________________________
Signature Date