AMERICAN FAMILY ORTHODONTICS

Adult Information Sheet

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: ____________________

____

____

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.: ____________________

Employer: ____________________

Medical History

Has the patient ever been treated for any of the following?

Diabetes .... ❑ Yes ❑ No

Asthma .... ❑ Yes ❑ No

Pneumonia .... ❑ Yes ❑ No

AIDS/HIV .... ❑ Yes ❑ No

Heart Trouble .... ❑ Yes ❑ No

Kidney Involvement .... ❑ Yes ❑ No

Hepatitis .... ❑ Yes ❑ No

Prolonged Bleeding .... ❑ Yes ❑ No

Rheumatic Fever .... ❑ Yes ❑ No

Fainting or Dizziness .... ❑ Yes ❑ No

Bone Disorder .... ❑ Yes ❑ No

Nervous Disorder .... ❑ Yes ❑ No

Headaches .... ❑ Yes ❑ No

Psychiatry .... ❑ Yes ❑ No

Endocrine .... ❑ Yes ❑ No

Genetics .... ❑ Yes ❑ No

Anemia .... ❑ Yes ❑ No

Skin Disorders .... ❑ Yes ❑ No

Other ____________________

Are you in good health? .... ❑ Yes ❑ No

Have tonsils and adenoids been removed? ... ❑ Yes ❑ No Age____

Has patient received a blood transfusion since 1980?

❑ Yes ❑ No

Has patient been exposed to the AIDS virus? ______ ❑ Yes ❑ No

Current medications? ____________________

Reason? ____________________

____

Are there any problems with the jaw? .... ❑ Yes ❑ No

❑ Clicking ❑ Pain ❑ Opening ❑ Chewing

Has there been any injuries to the face, mouth or teeth?

❑ Yes ❑ No

Explain ____________________

Mouth breather? .... ❑ Yes ❑ No

While awake or asleep? ____________________

Have you ever been informed of any missing or extra teeth?

❑ Yes ❑ No

Have you seen another orthodontist? .... ❑ Yes ❑ No

Has any member of the family received orthodontic treatment?

❑ Yes ❑ No

Reason for consultation? ____________________

I authorize the information to be correct. I understand it is my responsibility to notify American Family 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