DOPAZO ORTHODONTICS

Please complete this form and bring it to your new patient appointment.

WE LOOK FORWARD TO YOUR VISIT!

PATIENT INFORMATION

Patient's Name:	Preferred Name:	Today's Date:
SEX: ☐ Male ☐ Female		Date of Birth:
Social Security Number:		Age:
Home Address: City/State/ZIP		Home Phone: E-Mail:
Employer:		Work Phone:
Whom may we thank for referring you:		General Dentist:
Please list other family members treated here:		

SPOUSE INFORMATION

Spouse's name:	Date of Birth:
Home Address: (*if different from patient*)	Home Phone: E-Mail:
Social Security Number:	Occupation:
Employer:	Work Phone:

DENTAL/ALLERGY HISTORY

Date of last dental visit:	Purpose of last visit:
What are the main concerns that you would like orthodontics to accomplish?	
Have you been evaluated for orthodontic treatment before?	☐ Yes ☐No
Have you had any injuries to the face, mouth or chin?	☐ Yes ☐No
Have you been informed of any missing or extra permanent teeth?	☐ Yes ☐No
Have you had any pain/tenderness in his/her jaw joint (TMJ/TMD)?	☐ Yes ☐No
Have you had a serious/difficult problem associated with any previous dental work?	☐ Yes ☐No
Do you have any speech problems?	☐ Yes ☐No
Do you generally breathe through your mouth while sleeping?	☐ Yes ☐No
Do you generally breathe through your mouth while awake?	☐ Yes ☐No
Do your gums ever bleed?	☐ Yes ☐No
Do you smoke or use tobacco in any form?	☐ Yes ☐No
Do you like your smile?	☐ Yes ☐No
How would you describe your current dental health? ☐ Good ☐ Fair ☐ Poor	

Allergies:

Do you have any of the following allergies?

Aspirin	☐Yes	☐No	**Codeine**	☐Yes	☐No	**Dental Anesthetics**	☐Yes ☐No
Latex	☐Yes	☐No	**Metal**	☐Yes	☐No	**Erythromycin**	☐Yes ☐No
Penicillin	☐Yes	☐No				**Tetracycline**	☐Yes ☐No

Handicaps/Disabilities:

More IMPORTANT details need to be completed on the back of this form. Thank you!

For Office Use ONLY	**Patient I.D.#**

MEDICAL HISTORY

Patient's Physician:	Phone Number:	Date of Last Visit:
Emergency Contact:	Phone Number:	Relationship:

Medical Conditions:					
Have you ever had any of these medical conditions?	Abnormal Bleeding	□Yes □No	Heart Disease	□Yes □No
	ADD/ADHD	□Yes □No	Heart Murmur	□Yes □No
	Anemia/Radiation Treatment	□Yes □No	Hemophilia	□Yes □No
	Artificial Bone/Joint/Valves	□Yes □No	Hepatitis (□A □B □C)	□Yes □No
	Arthritis	□Yes □No	High/Low Blood pressure	□Yes □No
	Asthma	□Yes □No	Kidney/Liver Problems	□Yes □No
	Cancer/Leukemia	□Yes □No	Measles/Mumps	□Yes □No
	Cerebral Palsy	□Yes □No	Mitral Valve Prolapse	□Yes □No
	Congenital Heart Defects	□Yes □No	Mononucleosis	□Yes □No
	Diabetes	□Yes □No	Pregnant (currently)	□Yes □No
	Drug/Alcohol Abuse	□Yes □No	Psychiatric Problems	□Yes □No
	Fever Blisters	□Yes □No	Rheumatic/Scarlet Fever	□Yes □No
	Hearing Impairment	□Yes □No	Thyroid Disease	□Yes □No
	Heart Attack/Problems	□Yes □No	Tuberculosis (TB)	□Yes □No

Please discuss any medical problems you have had:

Please list any current medications being used and the reason for each:

Are you currently taking or have you **EVER** taken medications to prevent bone loss/osteoporosis (i.e. Actonel, Fosamax, Boniva, intravenous bisphosphonates)? □Yes □No

RESPONSIBLE PARTY INFORMATION *complete only if different from patient*

Person Financially Responsible:	Date of Birth:
Relationship to Patient	Social Security Number:
Billing Address:	Home Phone: E-Mail:
Employer:	Work Phone:

INSURANCE INFORMATATION

Do you have orthodontic coverage? □Yes □No	Employer:	
Insurance Company:	Insured's Name:	
Insurance Claims Address:	Insured's Date of Birth:	
	I.D. #	Group #
Insurance Company Phone:	Social Security # (required):	

Financial Information Signature Requirement

If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and/or deductibles that my insurance does not cover.

Signature of Patient/Responsible Party Date

This office reserves the right to verify credit of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature of Patient/Responsible Party Date

Treatment Authorization Signature Requirement

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform and necessary dental services I may need during diagnostic and treatment.

Signature of Patient/Responsible Party Date

For Office use ONLY

I Verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments:

Doctor's Initial: Date:

DOPAZO ORTHODONTICS

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- You may be contacted by the office to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new 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 through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

The office has the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information 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; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that these new provisions will be provided to you with a copy of the revised Privacy Notice.

Please note that the office is not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, 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.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient's/Parent's/Guardian's Signature	Date

DOPAZO ORTHODONTICS

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services.

Prior to commencing your orthodontic treatment, you are requested to review, sign and date this form. Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent. You have the right to request restrictions on the use of your protected health information. However, the office is not required to, and may not, honor your request.

The privacy notice may be amended at any time. You will be provided with a copy of the changes, and these changes may not be implemented prior to the effective date of the revised notice. You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Please let us know if you have any questions. Thank you for your cooperation.

_____

Patient's/Parent’s/Guardian’s Signature

_____

Print Name

_____

Date