AMERICAN FAMILY ORTHODONTICS

Adult Information Sheet

PATIENT INFORMATION

Date: ______

Patient's Name: ______

Date of Birth: ______ Age: ______ Sex: ______

Social Security #: ______

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: ______

Other Phone: ______

Person Responsible for Account: ______

Social Security #: ______

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 #: ______ DOB ______

Patient ID #: ______

Employer: ______

Medical History

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

Diabetes . . . . ❑ Yes ❑ No

Allergic to Latex . . . . ❑ 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 been advised to be premedicated? ❑ Yes ❑ No

If yes, please explain: ______

______

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