LAKEWOOD PARK ORTHODONTICS

PATIENT INFORMATION

Name: Last First Middle In.

Address: Street City State Zip

How long at this address? Home Phone Cell Phone Work Phone

Birthdate (MM/DD/YYYY) SSN: Marital Status

Employer Occupation No. Years Employed

Spouse's Name Last First Middle In.

Birthdate (MM/DD/YYYY) SSN: Cell/Work Phone

Spouse's Employer Occupation No. Years Employed

How did you hear about our office?

DENTAL INSURANCE INFORMATION

Insurance Company Subscriber's Name (If Different than Above)

Subscriber's ID No. Subscriber's Group No. Subscriber's Local No.

Insurance Co. Address Ins. Co. Phone No.

Do you have dual coverage? *(Circle)* **NO** **YES** *If yes, please fill out the below:*

Insurance Company Subscriber's Name (If Different than Above)

Subscriber's ID No. Subscriber's Group No. Subscriber's Local No.

Insurance Co. Address Ins. Co. Phone No.

EMERGENCY INFORMATION

Emergency Contact Name Phone No.

Address: Street City State Zip

Signature:_____ Date:_____

MEDICAL HISTORY

Physician | Date of Last Visit | Phone No.

Address: Street | City | State | Zip

Please Circle YES or NO			*If YES, please fill in details*
Are you taking any medication?	NO	YES	
Are you allergic to any medication?	NO	YES	
Do you have a history of a major illness?	NO	YES	
Have you had any operations?	NO	YES	
Have you ever been involved in a serious accident?	NO	YES	
Have you ever smoked or chewed tobacco?	NO	YES	
Have you seen a physician in the last 12 months?	NO	YES	
Are you allergic to latex?	NO	YES	
Are you allergic to any metals?	NO	YES	
Female Patients Only			
Has menstruation started?	NO	YES	
Are you pregnant?	NO	YES	

Circle any of the medical conditions below which you have had or currently have:

Abnormal Bleeding	Hemophilia	Diabetes	Hepatitis	Asthma
Prolonged Bleeding	Anemia	Arthritis	Dizziness	Pneumonia
Herpes	High Blood Pressure	Epilepsy	Hearing Impaired	Hayfever
Radiation/Chemotherapy	Tumor or Cancer	Heart Murmur	Rheumatic Fever	Tuberculosis
HIV/AIDS	Heart Problems	Liver Problems	Kidney Problems	Bone Disorders
Nervous Disorders	Congenital Heart Defect	Gastrointestinal Disorders		

Are there any medical conditions not listed of which you feel we should be aware?

DENTAL HISTORY

General Dentist | Date of Last Visit | Phone No.

Address: Street | City | State | Zip

What concerns you most about your teeth?

Please Circle YES or NO			*If YES, please fill in details*
Are you presently in any dental pain?	NO	YES	
Have you ever experienced any unfavorable reaction to dentistry?	NO	YES	
Have your wisdom teeth been removed?	NO	YES	
Have you ever lost or chipped any teeth?	NO	YES	
Have there been any injuries to face, mouth, or teeth?	NO	YES	
Is any part of your mouth sensitive to temperature or pressure?	NO	YES	Where?
Do your gums bleed when you brush?	NO	YES	
Do you have any type of thumb or tongue habit?	NO	YES	
Are you a mouth breather?	NO	YES	
Have you ever seen an orthodontist before?	NO	YES	Who and when?
What is your attitude toward receiving orthodontic treatment?			
Has anyone in your family received orthodontic treatment?	NO	YES	
How did they feel about the result?			
Do your teeth or jaws ever feel uncomfortable when you awake in the morning?	NO	YES	
Are you aware of your jaw clicking or popping?	NO	YES	
Are you aware of clenching your teeth during the day?	NO	YES	
Have you ever been told that you grind your teeth?	NO	YES	
Do you have “tension” headaches?	NO	YES	
Have you ever experienced chronic ringing in your ears?	NO	YES	
Are you aware that some appointments will be during work hours?	NO	YES	

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize **Dr. Hughes** to perform a complete orthodontic evaluation.

Signature:_____Date:_____ Dr.’s Initials_____

LAKEWOOD PARK ORTHODONTICS

Patient Name: _____ Date of Birth:_____

I agree that Lakewood Park Orthodontics may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: 508-319-1545

Patient/Guardian Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient Signature:_____

Date:_____

LAKEWOOD PARK ORTHODONTICS

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)