

**PATIENT INFORMATION**

|  |  |  |
| --- | --- | --- |
| Name: Last | First | Middle In. |
| Address: Street | City | State | Zip |
| Home Phone |  Cell Phone |  | Work Phone |
| Birthdate (MM/DD/YYYY) |  Preferred Pronoun: |  |
| How did you hear about our office? |

**DENTAL INSURANCE INFORMATION**

|  |  |
| --- | --- |
| Insurance Company | Phone Number |
| Address |    |  |
| Subscriber’s Name Date of Birth  |  |
| Subscriber ID # Group # |  |
| Do you have dual coverage? (Circle) **NO YES** | If yes, please fill out the below: |
| Insurance Company | Phone Number |
| Address |   |  |
| Subscriber’s Name Date of Birth  |  |
| Subscriber ID# Group # |  |

**EMERGENCY INFORMATION**

|  |  |
| --- | --- |
| Emergency Contact Name | Phone No. |
| Address:  | City | State | Zip |
| Relationship to Patient |  |  |  |

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 |
| Frequent Headaches | Anemia | Arthritis | Dizziness | Pneumonia |
| Herpes/Fever Blister | High Blood Pressure | Epilepsy | Hearing Loss | Hayfever/Sinus Issues |
| Radiation/Chemotherapy | Tumor or Cancer | Heart Murmur | Rheumatic Fever | Tuberculosis (TB) |
| HIV/AIDS | Heart Problems | Liver Problems | Kidney Problems | Bone Disorders |
| Dental Anxiety | Congenital Heart Defect | Gastrointestinal Disorders Sleep Apnea | Artificial Joint/Valve |
| ***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 or do you snore? | NO | YES |  |
| Have you ever seen an orthodontist before? | NO | YES | Where 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 |  |

**SOME BENEFITS AND RISKS OF ORTHODONTIC TREATMENT**

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 have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history in the future. In addition, I authorize **Dr. Hughes** to perform a complete orthodontic evaluation. If orthodontic treatment commences, a more thorough informed consent will be provided.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.’s Initials\_\_\_\_\_\_\_\_\_\_\_



**Electronic Communication Consent**

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):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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**

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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)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
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