PATIENT INFORMATION FORM

PATIENT

Patient's Name_____ Preferred Name_____

Date of Birth_____ Sex_____ Home/Cell Phone _____

How would you prefer to receive reminder calls? Voicemail_____Text message_____

Custodial Parent name_____Work Phone_____

Address_____City_____St_____Zip _____

Patient's School_____Email Address_____

Patient's Dentist_____Patient's Physician_____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account _____

Address (if different than above)_____

Email address _____Relationship to Patient_____

Home Phone _____Cell Phone_____Work Phone_____

Employer name_____

DENTAL INSURANCE

Primary Policy holder's full name _____Date of birth_____

Social Security #_____ Relationship to patient_____

Insurance Company_____

Group #_____ID #_____

Insurance address_____

Insurance phone #_____Policy holders employer_____

Secondary policy holder's full name_____ Date of birth_____

Social security #_____ Relationship to patient_____

Inusrance company_____

Group #_____ID#_____

Insurance address_____

Insurance phone #_____Policy holders employer_____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in the patient's medical or dental health.

I authorize release of any information regarding the patient's orthodontic treatment to my dental and/or medical insurance company.

*Patient/Parent/Guardian Signature*_____

MEDICAL HISTORY FORM

Patient Medical History

Patient Name:_____Birthday:_____

Parent/Guardian:_____

Have you been under the care of a physician in the last two years:_____

Do you require pre-medication (antibiotic prophylaxis) prior to dental treatment:_____

Have you ever had or do you now have any of the following:

____Prolonged Bleeding
____Cancer
____Epilepsy
____Anemia
____Diabetes
____Asthma
____Heart Problems
____Fainting
____Rheumatic Fever
____Nervous Disorder
____Bone Disorders
____Endocrine Problems
____Tuberculosis
____Liver Problems
____Hepatitis
____Birth Defects
____Aids or HIV
____Anemia
____Allergies_____

Have you had any operations?
____ Yes _____No

Have you been hospitalized?
____ Yes _____No

List any medications you are now on:
_____
_____

List any other serious illness and operations not listed above:_____

Patient's Dental History

Do you have any of the following:

___Any family members who have had orthodontics.
___Teeth sensitive to hot/cold.
___ Injuries to your face, jaw, mouth or teeth.
___Bleeding gums, bad taste in mouth.
___Root canals, crowns, or bridges.
___Suck your thumb and/or fingers.
___Any clicking, popping or pain of the jaw, joints (TMJ).
___Any missing teeth or extra teeth.
___Trouble chewing.

Date of most recent dental exam_____

What is the main thing you would like to find out by coming to see Dr. Adams and what would you like to see done to your smile?

_____
_____
_____

Who may we thank for referring you to our office?_____

How did you hear about our office?

___Television ___Website ___Social Media ___Word of Mouth ___Yellow Pages

___Other_____

Signature (Parent if minor):_____

ADAMS ORTHODONTICS
BRADLEY ADAMS, DMD, MS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for Dr. Bradley O. Adams.
Patients Name_____
Patient or Parent/Guardian Signature_____
Date_____

Attempt was made to obtain acknowledgement but could not be obtained for the following reason:
____ Individual refused to sign
____Communication barriers prohibited obtaining signature
____Other-specify

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC AND/OR VIDEO IMAGES

AUTHORIZATION:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy regulations.
PURPOSE: The photographic/video Images, and/or testimonial will be used for: Social Media and/or Advertising.
Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.
NO TREATMENT CONDITIONS:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

PATIENT NAME:_____
Date:_____
Signature:_____

IF PERSONAL REPRESENTATIVE
Name:_____
Date:_____
Signature:_____
Relationship to patient:_____

IF PATIENT IS A MINOR
Parent/Legal Guardian:_____
Date:_____
Signature:_____

If desired, copy provided:
O "*Yes, I would like a copy of this form.*"
(initialed by team member, copy provided by _____)

PRACTICE NAME: ADAMS ORTHODONTICS