Health History Form

Patients Name: _____ Patients Date of Birth: _____

Patients Preferred Name To Be Called: _____

Responsible Party Name: _____

Responsible Party Date of Birth: _____

Responsible Party Social Security Number: _____- _____- _____

Marital Status _____

Responsible Party Cell Phone: _____

Responsible Party Email Address: _____

Responsible Party Home Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Occupation: _____

Insurance Information

Insured's Name _____ Insured SS #: _____-_____-_____

Insurance Co. _____

Insurance Member ID: _____ Insurance Group #: _____

Insurance Phone #: _____ Insured Employer: _____

If you have duel insurance coverage please complete:

Insured's Name _____ Insured SS #: _____-_____-_____

Insurance Co. _____

Insurance Member ID: _____ Insurance Group #: _____

Insurance Phone #: _____ Insured Employer: _____

Dental History

Dentist Name: _____ Phone: _____

Date of last Dental Cleaning / Checkup: _____

Any future Dental procedures planned? _____

Please Check Next To Yes or No

Yes No Are you currently under any medical treatment?

Yes No Do you have pain, clicking and/or popping noises in the jaw?

Yes No Are you aware of either clenching or grinding of the teeth?

Yes No Do you have frequent headaches? How often? _____

Yes No Do you have ear problems, either aches, ringing, dizziness, fullness?

Yes No Do you have difficulty breather through the nose?

Yes No Do you have habits such as nail biting, finger or thumb sucking?

Yes No Do you have speech problems, or are you in speech therapy?

Yes No Has there been a history of joint swelling, asthma, TB, Aids, Kidney, Liver Condition, Epilepsy, Rheumatic Fever, Other Major Illness?

If Yes to the above question, please list which ones: _____

_____

Yes No Is there a tendency to faint or become dizzy?

Yes No Are you currently taking any medications?

If Yes to the above question, please list which ones: _____

Yes No Do you have a heart condition?

Yes No Do you pre-medicate?

If Yes to the above question, your Cardiologist name? : _____

Yes No Do you have sleep apnea?

Yes No Do you smoke or chew tobacco?

Responsible Party Signature: _____

Date: _____

This Notice Describes How Medical Information About You And / Or The Patient May Be Used And Disclosed And How You Can Get Access To This Information

Please Review This Carefully,

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all Dental records and other individually identifiable health information used to disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation on how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternative or other health related benefits and services that may be of interest to you.

Any other use and disclosures will be made only with your written authorization. You may revoke such authorization in writing requests to the Privacy Officer.

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 form, I am giving my consent to your use and discloser of my protected health information to carry out treatment, payment activities and health care options.

Signature: _____ **Date: _____**

1. Have you had orthodontic treatment before?
   _____ Yes
   _____ No

2. What was your prior orthodontic treatment?
   _____ Traditional Braces
   _____ Plastic Aligners

3. Why are you seeking treatment?
   _____
   _____

4. What are your chief concerns?
   _____
   _____

5. Do you have a treatment in mind?
   _____ I don't know; I need to learn more
   _____ Hidden Braces (behind the teeth)
   _____ Traditional Braces
   _____ Aligners
   _____ Retainers

6. Why? (check all that apply)
   _____ Invisible
   _____ Colors
   _____ Ease of use
   _____ My friend recommend it
   _____ I think this will be faster
   _____ Minimal effort
   _____ None of the above

7. How did you hear about this treatment?
   _____ Friend
   _____ Social Media
   _____ Commercial Dentist
   _____ Other

8. Why have you held back on treatment until now?
   _____
   _____

9. How often you drink or sip on non-water beverages (juices, soda, coffee, tea, win, etc)?
_____ All day
_____ Most of the day
_____ Half of the day
_____ Less than half of the day
_____ Less than 1 hour of the day
_____ Never

10. How often do you attend social events (meals with friends / colleagues / clients / work events / parties / dates / etc)?
_____ 5+ times per week
_____ 2-3 times per week
_____ 2 to 4 times per month
_____ Almost never

11. Do you speak often for work?
_____ Yes, all the time
_____ Most of the time
_____ Some of the time
_____ Never

12. Do you have any upcoming life events (wedding /engagement / graduation / speaking event / work conference / important family event) that we should be prepared for?

Dave / Event

_____

Dave / Event

_____