

ADULT PATIENT INFORMATION

Patient Name: _____ DOB: ____ / ____ / ____
 Sex: Male/Female Preferred Pronouns: She/Her, He/Him, They/Them
 _____ Preferred Name (Nickname): _____ SSN: _____ - _____ - _____
 Physical Address: _____ City: _____ Zip: _____
 Preference for contact: Text or Email (Circle one or both)
 Cell Phone: (____) _____ - _____ Cell phone carrier (for text msgs): _____
 Email Address: _____
 Home phone #: (____) _____ - _____ Work phone #: (____) _____ - _____
 Employer: _____ Length of employment: _____ years
 Occupation/Job Title: _____
 Marital status: (please circle) Single / Married / Divorced / Domestic partner / widowed
 Whom may we thank for referring you to our office?: _____
 Current Dentist: _____
 Reason for today's visit? (in your own words): _____

SPOUSE OR DOMESTIC PARTNER INFORMATION

Name: _____ Sex: M/F Birth Date: ____ / ____ / ____
 Physical Address: (if different from above) _____ City: _____ Zip: _____
 Cell Phone: (____) _____ - _____ Email Address: _____
 Additional phone #: _____ (cell/work/home/other)
 Additional phone #: _____ (cell/work/home/other)
 Employer: _____ Length of employment: _____ years
 Occupation/Job Title: _____

INSURANCE INFORMATION (DENTAL ONLY)
Primary Dental Insurance

Insurance company: _____
 Subscriber's Name: _____
 DOB: ____ / ____ / ____
 Member ID#: _____
 Group #: _____
 Insurance Phone #: (____) _____ - _____
 Patient's relation to subscriber: _____

Secondary Dental Insurance

Insurance company: _____
 Subscriber's Name: _____
 DOB: ____ / ____ / ____
 Member ID#: _____
 Group #: _____
 Insurance Phone #: (____) _____ - _____
 Patient's relation to subscriber: _____

EMERGENCY CONTACT (person not living with you ie: close family friend or relative)

Name: _____ Relation to patient: _____
 Address: _____
 Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

The information that I have given is correct to the best of my knowledge

Parent Signature: _____ Date: _____

HEALTH QUESTIONNAIRE

Medical Physician's Name: _____ Physician's Phone # (____)_____- _____
Date of last physical: _____ (**Women:** are you, or could you be pregnant)? Y/N
Currently under physician's care for the following: _____
Has the patient been hospitalized? If yes, please explain _____

Does the patient now, or has the patient ever had any of the following diseases or conditions?

Please circle Yes or No in response to the following questions. Your answers will be CONFIDENTIAL.

ADD or ADHD	Yes ___ No ___	Hypertension	Yes ___ No ___
AIDs (HIV positive)	Yes ___ No ___	Kidney Disease or Infection	Yes ___ No ___
Anxiety Disorder	Yes ___ No ___	Liver Disease	Yes ___ No ___
Asthma	Yes ___ No ___	Painful or Swollen Joints	Yes ___ No ___
Autism	Yes ___ No ___	Prosthetic Valves, Joints or Screws	Yes ___ No ___
Blood Disorders or Transfusions	Yes ___ No ___	Radiation Treatment	Yes ___ No ___
Diabetes	Yes ___ No ___	Severe Headaches	Yes ___ No ___
Epilepsy or Seizures	Yes ___ No ___	Stroke	Yes ___ No ___
Heart Attack	Yes ___ No ___	Tonsils or Adenoids Removed	Yes ___ No ___
Hemophilia	Yes ___ No ___	Tuberculosis	Yes ___ No ___
Hepatitis (A, B, or C)	Yes ___ No ___	Tumor or Growth	Yes ___ No ___
Herpes	Yes ___ No ___	Ulcer or Acid Reflux	Yes ___ No ___

Has the patient ever been told by a physician that they have a heart murmur? Y/N

Has a physician or dentist recommended pre-medication with antibiotics before dental treatment? Y/N

Has the patient ever had any heart trouble, artificial valves, or rheumatic fever? Y/N

Does the patient now, or has the patient ever used tobacco products? Y/N

Has the patient ever taken medication for osteoporosis? Y/N Name of medication: _____

Does the patient have any **allergies (to latex, metals, etc.)?** Y/N **Please list** _____

Has the patient experienced any unusual **reactions or allergies** to any of the following drugs?

Penicillin	Yes ___ No ___	Dental Anesthetic	Yes ___ No ___
Antibiotics	Yes ___ No ___	Sulfa Drugs	Yes ___ No ___
Aspirin	Yes ___ No ___	Others, please list :	

Please list all current medication and/or herbal supplements the patient is taking:

DENTAL HISTORY

Does the patient have a history of any of the following?

Missing or extra teeth	Yes ___ No ___	TMJ problems	Yes ___ No ___	History of thumb sucking	Yes ___ No ___
Chipped or injured teeth	Yes ___ No ___	Clenching or Grinding	Yes ___ No ___	Abnormal swallow	Yes ___ No ___
Jaw fractures	Yes ___ No ___	Loose or shifting teeth	Yes ___ No ___	Negative dental experience	Yes ___ No ___
Damaged or lost fillings	Yes ___ No ___	Periodontal disease	Yes ___ No ___	Is all dental work complete?	Yes ___ No ___

Has the patient had previous orthodontic treatment? Y/N

**I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that the questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any later changes to this history, medical, or dental status, I will inform the practice.

Signature (Parent's signature if minor)

Date

Notice of Privacy Practices

Statement of Privacy Practices

We, at Sound Orthodontics, are dedicated to protecting the privacy of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies but will always inform you of any change that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act of Washington. This includes issues relating to your treatment, payment, and our orthodontic care operations. Your personal health information will never be otherwise given to anyone even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality orthodontic care, implement payment activities, conduct normal orthodontic operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if necessary. Regardless of the source, your personal information will always be protected to the fullest extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about future appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices for Sound Orthodontics. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Sound Orthodontics reserves the right to change the privacy practices that are described in the Notice of Privacy. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

Signature of responsible party

Date

Is there an additional person with whom we may share your information? _____

Name

Relation

Record of Acknowledgement not obtained

Reason for denial:

_____ Needed more time to review Notice of Privacy Practices

_____ Wanted to consult with another person before signing

_____ Unable to sign

_____ Reason not given