sound orthodontics

Date: _____

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

STATEMENT OF PRIVACY PRACTICES

SOUND ORTHODONTICS

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and 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 and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to 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 HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice 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 it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

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 U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Sound Orthodontics. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

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

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	