Bonney Lake ORTHODONTICS

Confidential Patient Information

Patient's Name:
Last First Middle

Address:
Street City State Zip

Home Phone: Birth date: Social Security:

School: Grade: Hobbies:

If patient is a minor, give parent's or guardian's name:

Whom may we thank for referring you to our office?

Names and ages of siblings:

Confidential Responsible Party Information

Name: Relationship to Patient:
Last First Middle

Address:
Street City State Zip

How long at this address: Home Phone: Cell Phone:

Email Address: Work Phone:

Social Security #: Birth date: Marital Status:

Employer: Occupation: No. Years Employed:

Spouse's Information

Name: Relationship to Patient:
Last First Middle

Social Security #: Birth date: Cell Phone:

Employer: Occupation: No. Years Employed:

Emergency Information

Name of nearest relative not living with you:

Phone: Relationship:

Dental Insurance Information

Policy Holder's Name: Member# **OR** Soc Sec. #:

Insurance Company: Group No.: Union Local No.:

Insurance Co. Address: Insurance Co. Phone:

Policy Holder's Employer:

Do you have dual coverage? No ☐ Yes ☐ If yes, please fill out boxes below

Policy Holder's Name: Member# **OR** Soc Sec. #:

Insurance Company: Group No.: Union Local No.:

Insurance Co. Address: Insurance Co. Phone:

Policy Holder's Employer:

Assignment & Release

I hereby authorize payment directly to Bonney Lake Orthodontics for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize release of any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: **Date:**

Patient Health Information

What are your main reasons for seeking orthodontic treatment? _____

_____

Have you ever been evaluated or had orthodontic treatment before?	☐ Yes	☐ No
Have there been any injuries to your face, mouth, teeth, or chin?	☐ Yes	☐ No
List any musical instruments played: _____		
Have your adenoids and/or tonsils been removed?	☐ Yes	☐ No
Have you been informed of any missing or extra permanent teeth?	☐ Yes	☐ No
Have you ever had any pain/tenderness in the jaw joint (TMJ/TMD)?	☐ Yes	☐ No
Do you see your dentist regularly for check-ups (i.e. at least every 6 months)?	☐ Yes	☐ No
Do you brush/floss your teeth daily?	☐ Yes	☐ No
Are you currently pregnant or think you may be?	☐ Yes	☐ No

Patient's dentist: _____ Date of last visit: _____

Patient's physician: _____ Date of last visit: _____

Please list all the medications that you are currently taking: _____

Please list all the medications, substances, or metals, that you are allergic to:_____

Have you ever had any of the following medical problems?

Abnormal Bleeding	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Allergic to Plastic	☐ Yes ☐ No
Allergic to Latex / Metals	☐ Yes ☐ No	Heart Defect/Murmur	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Handicaps / Disabilities	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Any Hospital Stays	☐ Yes ☐ No	Any Operations	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Kidney / Liver Problems	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	HIV / AIDS	☐ Yes ☐ No
Convulsions / Epilepsy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Please describe any medical problems you have had, current/past bisphosphonate use, and/or periodontal therapy:_____

_____

Do you have any of the following habits?		Clenching/Grinding Teeth	☐ Yes ☐ No	Tongue Thrust	☐ Yes ☐ No
Speech Problems	☐ Yes ☐ No	Lip Sucking/Biting	☐ Yes ☐ No	Nail Biting	☐ Yes ☐ No
Mouth Breather	☐ Yes ☐ No	Thumb / Finger Sucking	☐ Yes ☐ No	Tobacco Use	☐ Yes ☐ No

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature (Parent's signature if minor) **Date**

Updates (date & initial) _____ Updates (date & initial) _____

Acknowledgment 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 Bonney lake 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. Bonney Lake Orthodontics reserves the right to change the privacy practices that are 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 to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my/my child's protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY ☐ Yes ☐ No SPOUSE ONLY ☐ Yes ☐ No OTHER ***(PLEASE SPECIFY):*** _____

_____ _____

Signature of Patient or Personal Representative **Date**