Please fill out this form completely, it is important to your dental care. Our goal is to help you reach and maintain good oral health.

# Welcome to the Orthodontist

## About You

Today's Date: _____

Name: _____ ☐M ☐F
Last First MI

Birthdate: ____/____/____ Age: _____ SS# : _____

Home Address: _____

_____
City State Zip

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Hm #: (____)_____ Cell #: (____)_____

Wk #: (____)_____ DL #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

What time is best to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Dentist Name: _____

Previous or Present (Please Circle) Date of last visit? _____

**Person Responsible for Account:** _____

## Spouse Information

His/Her Name: _____

Employer: _____

Wk #: (____)_____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Relative or friend not living with you.

Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

## Orthodontic Insurance

### PRIMARY

Orthodontic Coverage? ☐Y ☐N Dental Coverage? ☐Y ☐N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

### SECONDARY

Orthodontic Coverage? ☐Y ☐N Dental Coverage? ☐Y ☐N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment that my insurance does not cover, including the deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____ _____
SIGNATURE DATE

Continued on Back

# Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Ph #: (_____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Y ☐ N

Have you had any metal rods, pins or implants? ☐ Y ☐ N

Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N

Please list each one: _____

Have you ever taken Fosamax or any bisphosphonate? ☐ Y ☐ N

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

If so, when? _____

**WOMEN:** Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N Week #: _____

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical problems

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding/Hemophilia | Y | N | Herpes/Fever Blisters |
| Y | N | AIDS | Y | N | High Blood Pressure |
| Y | N | Alcohol / Drug Abuse | Y | N | HIV |
| Y | N | Anemia | Y | N | Hospitalized for Any Reason |
| Y | N | Arthritis | Y | N | Kidney Problems |
| Y | N | Artificial Bones/Joints/Valves | Y | N | Liver Disease |
| Y | N | Asthma | Y | N | Low Blood Pressure |
| Y | N | Blood Transfusion | Y | N | Lupus |
| Y | N | Cancer/Chemotherapy | Y | N | Mitral Valve Prolapse |
| Y | N | Colitis | Y | N | Pacemaker |
| Y | N | Congenital Heart Defect | Y | N | Psychiatric Problems |
| Y | N | Diabetes | Y | N | Radiation Treatment |
| Y | N | Difficulty Breathing | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Emphysema | Y | N | Seizures |
| Y | N | Epilepsy | Y | N | Shingles |
| Y | N | Fainting Spells | Y | N | Sickle Cell Disease/Traits |
| Y | N | Frequent Headaches | Y | N | Sinus Problems |
| Y | N | Glaucoma | Y | N | Stroke |
| Y | N | Hay Fever | Y | N | Thyroid Problems |
| Y | N | Heart Attack/Surgery | Y | N | Tuberculosis (TB) |
| Y | N | Heart Murmur | Y | N | Ulcers |
| Y | N | Hepatitis | Y | N | Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Erythromycin | Y | N | Penicillin |
| Y | N | Codeine | Y | N | Jewelry/Metals | Y | N | Tetracycline |
| Y | N | Dental Anesthetics | Y | N | Latex | Y | N | Other |

List any other drugs/material allergies: _____

_____ _____

# Dental History

What would you like orthodontics to accomplish?

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you still have wisdom teeth? ☐ Y ☐ N

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? ☐ Y ☐ N

Do you breathe through your mouth? ☐ While Awake ☐ While Asleep

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Do you like your smile? ☐ Y ☐ N

If not, what would you change? _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

SIGNATURE DATE

# Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

# Medical History Update

Has there been any change in your health status since your last visit? Y N

If Yes, please explain _____

_____

Has there been any change in your health status since your last visit? Y N

If Yes, please explain _____

_____

_____ _____

Patient Signature Date

_____ _____

Doctor Signature Date

_____ _____

Patient Signature Date

_____ _____

Doctor Signature Date

Beverly Hills Orthodontics

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Beverly Hills Orthodontics

# CONSENT FOR THE TRANSFER OF YOUR/YOUR CHILD'S HEALTH INFORMATION VIA EMAIL- EXAMPLES OF INFORMATION TO TRANSFERRED INCLUDE BUT ARE NOT LIMITED TO: RADIOGRAPHS, PHOTOGRAPHS, TREATMENT NOTES, WRITTEN CORRESPONDENCE REGARDING YOU OR YOUR CHILD'S TREATMENT

**PLEASE NOTE:** We are happy to respond to your request but in order for us to do so via email you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your request.

I, _____, authorize Beverly Hills Orthodontics and any all doctors and employees to send the requested information to the dental office below.

This consent form will also apply in the event you change your dentist of record, unless you direct otherwise.

Your name:

Your date of birth:

Patient name:

Patient date of birth:

Dentist name:

_____ _____

{Signature} {Date}

# BEVERLY HILLS ORTHODONTICS

Welcome to Beverly Hills Orthodontics!

In order to serve you better, please take a moment to answer these few questions. It will help the doctors understand your situation and enable them to provide you with the best possible solution.

1. Have you (or your child) had any orthodontic treatment in the past?

2. Have you (or your child) had an orthodontic evaluation before? If so, why haven't you considered treatment before?

3. Why are you interested in an orthodontic evaluation? What is most important to you when considering orthodontic treatment?

4. How long have you considered orthodontic treatment? Why are you considering treatment now?

# BEVERLY HILLS
# ORTHODONTICS

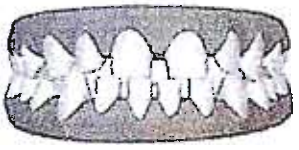
**What is your main concern?**

NAME: _____

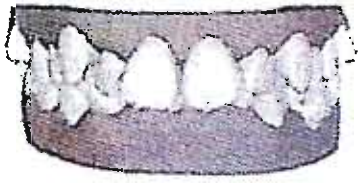
DATE: _____

Overjet (Buck teeth)

Spaced teeth



Crooked/Crowded teeth



OTHER (please fill in) _____

_____

**What style of treatment would you prefer?**

Metal Braces

Clear Braces

Invisalign