My
Orthodontist

✱ WELCOME TO OUR OFFICE

Please complete this Medical - Dental Questionnaire. It will help us to become better acquainted so that we can best meet your orthodontic needs.

✱ PATIENT AND FAMILY HISTORIES

Today's date:____________

1. Name of Patient (last)____________ (first)____________ (middle)____________ Sex: ☐ Male ☐ Female
2. Residence Address____________ City____________ State______ Zip______
3. Res. Telephone____________ School____________ Grade______
4. Date of Birth____________ Age: Years______ Months______
5. Name of Employer____________ Occupation____________
   Bus. Address____________ City____________ State______ Zip______
   Res. Telephone____________ Social Security Number____________
6. Name of Spouse____________ DOB____________ Occupation____________
   Social Security Number____________
   Address____________ Employed By____________
   City____________ State______ Zip______ Bus. Address____________
   Business Telephone____________
7. Patient is: ☐ married ☐ separated ☐ divorced ☐ widowed ☐ single
8. Who referred you to our office?____________
9. Do you have insurance that provides for orthodontic care?______ If so, please state name of insurance company and insurance numbers
   ____
10. Persons responsible for account____________
    Billing address____________
11. Who is the Insured? ☐ Patient ☐ Spouse

✱ DENTAL

1. Does patient have a regular dentist? ☐ Yes ☐ No
   If yes, is he/she ☐ your family dentist ☐ a specialist
   Please give name and address:____________
   ____
2. When did you last receive dental care?____________
3. How frequently do you brush your teeth?____________ Use dental floss____________
4. Have your teeth or either of your jaws been injured?____________ How old was the patient?____________
   What was the cause of the accident?____________
   Which teeth and/or jaw was involved?____________
5. Have you been informed of any missing or extra permanent teeth?____________
6. Do you have any jaw, joint or facial pain?____________
7. Do you have or ever had any of the following habits?____________
   ☐ lip sucking ☐ thumb sucking ☐ lip biting ☐ constant mouth breathing
   ☐ nail biting ☐ tongue thrusting ☐ grinding ☐ no oral habits
8. Do yout have any speech problems?____________
9. Please describe the orthodontic problem as you see it.____________
   ____
10. Describe anyone in your family with a similar dental or facial condition____________
11. Has anyone else in the family received orthodontic care?____________
12. Has an orthodontist been consulted previously?____________

✱ MEDICAL

1. Are you in good health? ❑ Yes ❑ No
2. Describe any major illnesses:____________________
3. Physician's name and address____________________
4. Check any of the following for which yout have been treated:

❑ Diabetes	❑ Tuberculosis	❑ Endocrine Problems
❑ Pneumonia	❑ Anemia	❑ Prolonged Bleeding
❑ Heart Trouble	❑ Epilepsy	❑ Fainting/Dizziness
❑ Rheumatic Fever	❑ Asthma	❑ Nervous Disorders
❑ Bone Disorders	❑ Kidney Involvement	❑ Liver Involvement - Hepatitis

5. Do you have a tendency to colds?________ Sore throat?________ Ear infections?________
6. Have tonsils been removed?________ Age________ Adenoids?________ Age________
7. List any drugs or medications now being taken. Give reasons:____________________
8. List any allergies or drug sensitivity:____________________
9. Height:________ Weight:________
10. Women: Are you now pregnant? ❑ Yes ❑ No

____

Parent / Guardian Signature

OFFICE USE ONLY

Diagnosis

1. alignment____________________
2. profile____________________
3. sagital____________________
4. transverse:____________________
5. vertical:____________________
6. other____________________
7. C.C.____________________

MY ORTHODONTIST
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ____________________ Email: ____________________

Patient Number: ____________________ Social Security#: ____________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice Privacy Practices, including any revisions of our Notice, at any time of by contacting:

Contact Person:	Christine Wallace or Michelle Greim		
Telephone:	215/946-0800	Fax:	215/946-1041
Email:	advanceddentistry@hotmail.com		
Address:	532 S. Oxford Valley, Fairless Hills, PA 19030		

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

____________________, 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 the Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations/

Signature: ____________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________

Relationship to Patient: ____________________