Patient Information

Name _____ Sex M F
Last First Middle

Address _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security _____
MM-DD-YYYY 999-99-9999

Home Phone _____ General Dentist _____ Last Visit _____
999-999-9999

Who may we thank for referring you to our office? _____

Responsible Party Information

Name _____ Birthdate _____ Marital Status _____
MM-DD-YYYY

Address _____

E-Mail _____ Social Security _____
999-99-9999

Home Phone _____ Cell Phone _____ Cell Carrier _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____

Name _____ Birthdate _____ Marital Status _____

Address _____

E-Mail _____ Social Security _____

Home Phone _____ Cell Phone _____ Cell Carrier _____

Employer _____ Occupation _____ No. Years Employed _____

Relationship to Patient _____

Insurance Information

Policy Owner's Name _____ Policy Owner's Employer_____

Insurance Company _____ Group No. _____ ID No. _____

Insurance Co. Address _____ Insurance Phone No. _____

Do You have Dual Coverage? Yes ____ No ____

Policy Owner's Name _____ Policy Owner's Employer_____

Insurance Company _____ Group No. _____ ID No. _____

Insurance Co. Address _____ Insurance Phone No. _____

Emergency Contact

Name _____ Relationship

Complete Address _____ Phone Number

Medical History

Is the patient currently under the care of a physician? Yes No

Medical Physician _____ Phone _____ Last Visit _____

Has the patient had their tonsils and adenoids removed? Yes No

Medication:

List all drugs patient is allergic to:

_____
_____
_____

List all drugs patient is currently taking:

_____
_____
_____

Has the patient ever had any of the following medical problems? (circle)

Heart murmur	Y	N	Congential Heart Defect	Y	N
Cancer	Y	N	Convulsions/Epilepsy	Y	N
Diabetes	Y	N	Abnormal Bleeding	Y	N
Rheum. Fever	Y	N	Hearing Impairment	Y	N
HIV+/AIDS	Y	N	Any Operations	Y	N
Hemophilia	Y	N	Any Stays in Hospital	Y	N
Asthma	Y	N	Kidney/Liver Problems	Y	N
Hepatitis	Y	N	Handicaps/Disabilities	Y	N
Tuberculosis	Y	N	Allergies	Y	N
Prothesis	Y	N	History of Scarlet fever	Y	N

Are there any medical conditions we have not discussed that you feel we should be aware of? If yes, please describe.

_____

Dental History

Does/Has the patient ever had any of the following habits?	Lip Sucking/Biting	Nail biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrust	Thumb/ Finger Sucking

Has the patient ever seen an orthodontist? Yes No

Has anyone in the family ever had orthodontic treatment? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever experienced pain in the jaw joint (TMJ/TMD)? Yes No

Has the patient ever had an injury to: (select all that apply) Teeth Mouth Chin

What is the main thing you would like to find out by coming to see Dr. Lauren and what would you like to see done for your smile?

_____
_____

Signature

I understand that information that I have provided is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform the office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need.
I understand that where appropriate, credit bureau reports may be obtained.

_____

Signature of patient/guardian Date

OFFICE USE ONLY--OFFICE USE ONLY--OFFICE USE ONLY

I have reviewed the medical/dental information above with the parent/patient & patient names herein.

Doctor's Comments:

_____

HIPAA CONSENT FORM

Advanced Orthodontics
2202 State Ave, Suite 200
Panama City, FL 32405

Patient Name:_____
Patient Date of Birth: _____

HIPAA – Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Advanced Orthodontics may use or disclose your protected health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Our Notice of Privacy Practices is available for you to view on our website, www.advancedorthodontics.info, or a copy can be obtained by contacting our office. Signing below indicates that you have had the opportunity to review the Notice of Privacy Practices.

I certify that I have had the opportunity to review the Notice of Privacy Practices of Advanced Orthodontics.

Name of Responsible Party_____

Relationship to Patient_____

Signature_____

Date_____

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Patient HIPAA Electronic Communications Acknowledgment and Consent Form

Unencrypted 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. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

____ I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is _____

____ I do NOT consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Date _____

Patient Name _____

Patient/Guardian Signature _____

AAO American Association of Orthodontists

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Last Name _____ **First Name** _____

Patient's Date of Birth _____

Patient's Address _____

I, _____, hereby authorize Advanced Orthodontics
(Name of Patient OR Parent/Legal Guardian if patient is under 18 years of age)
to release information, as indicated below, to the following person(s):

Name	Relationship to Patient	Phone Number	Check the Information to Release: Any	Clinical	Financial

I authorize Advanced Orthodontics to contact the individual(s) listed above to convey information as listed above regarding the 'patient' in the event that I am unable to be reached by Advanced Orthodontics.

I understand that I may revoke/cancel this authorization by notifying Advanced Orthodontics, in writing, of my intent to revoke authorization, or change the name(s) of those listed to whom the information is to be released.

_____ _____

Signature of Patient OR Parent/Legal Gaurdian if Patient is under 18 years of age

Date