PATIENT INFORMATION – ADULT

PATIENT

First Name: Last Name: Middle Initial:

Prefers to be called: Sex: ☐ male ☐ female Date of Birth:

Phone: Email:

Home Address:

Primary Responsible Party Information Is the Patient (listed above) the Primary Responsible Party? ☐ Yes ☐ No

First Name: Last Name: Middle Initial:

Mobile Phone: Email:

Date of Birth: Relationship to Patient: ☐ Male ☐ Female

Address:

How did you learn about our practice or whom may we thank for referring you?

Referral Source ☐ Google ☐ Dentist ☐ Social Media ☐ Sign or billboard ☐ Insurance Provider List

☐ Friend or family ☐ Other Website ☐ Other

What is your primary concern(s) about your teeth?

Have you had previous orthodontic treatment? ☐ Yes ☐ No

If yes, please explain:

Do you have a general dentist you see for cleanings? ☐ Yes ☐ No

General Dentist Information:

Dental Office Name: Provider Name:

Any scheduled treatments? Dental visit in last 6 months?: ☐ Yes ☐ No

Address:

Do you have Dental Insurance? ☐ Yes ☐ No

PRIMARY Insurance Information

Primary Insurance Company: Group Number:

Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other Member ID / Policy #:

Insured Full Name: Insured Date of Birth:

Insured Phone #: SSN: Employer:

Insured Address:

Primary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

Do you have additional Dental Insurance coverage? ☐ Yes ☐ No

SECONDARY Insurance Information

Secondary Insurance Company: Group Number:

Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other Member ID / Policy #:

Insured Full Name: Insured Date of Birth:

Insured Phone #: SSN: Employer:

Insured Address:

Secondary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

Medical History: *(include current and previous illnesses)*

	Yes	If yes, Explain
NO TO ALL	☐	
Anemia	☐	
Arthritis or Joint Problems	☐	
Asthma/COPD	☐	
Bleeding abnormally	☐	
Bone fractures/Major Injury	☐	
Cancer Treatment	☐	
Depression/Mental Health Disturbance	☐	
Diabetes	☐	
Eating Disorder	☐	
Emotional, Sensory, Developmental Issues	☐	
Endocrine or Thyroid Problems	☐	
Epilepsy	☐	
Fainting	☐	
GERD/Acid Reflux	☐	
Headaches/Migraines	☐	
Heart problems	☐	
Hepatitis	☐	
High blood pressure	☐	
Kidney Problems	☐	
Osteoporosis	☐	
Pacemaker	☐	
Rheumatic fever	☐	
Skin Disorder (other than common acne)	☐	
Stroke	☐	
Tobacco use	☐	
Vision, Hearing, Speech Problems	☐	

Other/Details:

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, please explain:

Dental History:

	Yes	If yes, Explain
NO TO ALL	☐	
Thumb/finger sucking	☐	
Tongue and/or swallowing problems	☐	
Speech problems	☐	
Loose teeth or broken fillings	☐	
Grinding and/or clenching of teeth	☐	
Tonsils and adenoids removed	☐	
Crowns/Bridges	☐	
Root canals	☐	
Mouth breathing	☐	
Snoring	☐	
History of wearing mouth guard	☐	
History of Periodontal disease or treatment	☐	
Mouth sores	☐	
Injury to face or teeth	☐	
Jaw Pain	☐	
Clicking or popping jaw	☐	
Difficulty opening or closing jaw	☐	
Sensitivity when biting	☐	
Cold, hot, or sweets sensitivity	☐	

Allergies:

	Yes	If yes, Explain
NO TO ALL	☐	
Latex (gloves, balloons)	☐	
Metals (jewelry, clothing snaps, etc)	☐	
Acrylics	☐	
Medication	☐	
Environtmental: Pollens, Grasses, Weeds, Dust, etc.	☐	
Animals	☐	
Foods	☐	
Other:	☐	

Some medications may have an effect on dental health and orthodontic treatment. It is important that we are aware of any and all medications you are taking as they may effect treatment recommendations/options/outcome. List all current medications and the correlating diagnosis:

Medication	**Frequency**	**Diagnosis**

Have you ever taken IV medications for bone disorders or cancer, including but not limited to biphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate), or Didronel (etidronate)? ☐ Yes ☐ No

If yes, please explain:

Have you ever taken oral medications for bone disorders or cancer, including but not limited to biphosphonates such as Fosamax (aledronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate)? ☐ Yes ☐ No

If yes, please explain:

What treatment option(s) interest you? ☐ Clear Aligners ☐ Clear/Metal Braces ☐ Retainers

If treatment is recommended, how soon would you like to get started? ☐ ASAP ☐ Within the week ☐ Within the month ☐ Other

What payment option(s) would you like to review?

☐ Interest Free Monthly Payment ☐ Payment in Full w/Special Courtesy ☐ HSA/FSA

Is there anything else you would like us to know before your visit?

Release and wavier: To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education. I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

_____ _____

Signature Date

iSmile Orthodontics

Privacy Practices

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. Some information may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

We may use and disclose your health information for your treatment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. We may use and disclose your health information in connection with our healthcare operations.

We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information. We will also use our professional judgement in allowing a person to pick up medications, medical supplies, x-rays, or other similar health information.

We may use or disclose your health information to assist in disaster relief efforts. We may use or disclose your health information when we are required to do so by law. We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to authorized federal officials for national security activities. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters). We may also contact you to provide information about treatment alternatives or other health-related information that may be of interest to you.

PATIENT RIGHTS

You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. You will receive notifications of breaches of your unsecured protected health information as required by law. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, please contact us using the contact information listed at the end of this Notice. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's notice of privacy practice, security and breach notification policies and procedures and I understand that I should ask our practice's Privacy Official if I have any questions about these policies and procedures

* Please ensure that you add anyone who could potentially accompany you/your child to future visits and anyone who may be making payments on the account in the future.

Signature: _____

Date: _____

Responsible Party gives permission to release patient information the following additional parties:

_____

(Name) (Relationship to patient)

_____

(Name) (Relationship to patient)

_____

(Name) (Relationship to patient)