TS Orthodontics and Dental Specialists

ADULT PATIENT INFORMATION

Date_____

Patient's name_____
Last First Middle Preferred

Residence_____
Street City Zip

Mailing Address_____
Street City Zip

How long at this address_____ Previous Address (If less than 3 years)_____

Home phone_____ Work phone_____Cell Phone_____Carrier_____

Date of Birth____/____/_____ Social Security Number_____Email Address_____

Employer_____ Occupation_____ No. years employed_____

Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

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

SPOUSE INFORMATION

Spouse's Name_____ Employer_____

Occupation_____ Years employed_____ Social Security Number _____

Date of Birth ___/___/_____Work Phone Cell Phone_____

ORTHODONTIC DENTAL INSURANCE INFORMATION

Insurance Company_____ ID Number_____Group No_____

Insurance Co. Phone Number_____Insurance Co. Address_____

Insured's Name_____Insured's Relationship to Patient_____Date of Birth_____/_____/_____

Insured's Social Security_____Insured's Employer_____

Do you have dual coverage? Yes_____ No_____ If yes, please complete the following.

Insurance Company_____ ID Number_____Group No_____

Insurance Co. Phone Number_____Insurance Co. Address_____

Insured's Name_____Insured's Relationship to Patient_____Date of Birth_____/_____/_____

Insured's Social Security_____Insured's Employer_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Complete address_____
Street City Zip

Home phone_____Work phone_____Cell phone_____

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MEDICAL HISTORY

Physician | Date of Last Visit
Address | Phone
Please circle Yes or No (If Yes, please fill in details)

Yes	No	Are you taking any medication?
Yes	No	Are you allergic to any medication?
Yes	No	Do you have a history of a major illness?
Yes	No	Have you had any operations?
Yes	No	Have you ever been involved in a serious accident?
Yes	No	Have you ever smoked or chewed tobacco?
Yes	No	Have you seen a physician in the last 12 months? Why?
Yes	No	Are you pregnant?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

DENTAL HISTORY

General Dentist | Date of last visit
What concerns you most about your teeth?

Yes	No	Are you presently in any dental pain?
Yes	No	Have you ever experienced any unfavorable reaction to dentistry?
Yes	No	Have your wisdom teeth been removed?
Yes	No	Have you ever lost or chipped any teeth?
Yes	No	Have there been any injuries to face, mouth, or teeth?
Yes	No	Is any part of your mouth sensitive to temperature? Where?
Yes	No	Is any part of your mouth sensitive to pressure? Where?
Yes	No	Do your gums bleed when you brush?
Yes	No	Do you have any type of thumb or tongue habit?
Yes	No	Are you a mouth breather?
Yes	No	Have you ever seen an orthodontist? If yes, who and when?
Yes	No	What is your attitude toward receiving orthodontic treatment?
Yes	No	Has anyone in your family received orthodontic treatment?
		How did they feel about the result?
Yes	No	Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
Yes	No	Are you aware of your jaw clicking or popping?
Yes	No	Are you aware of clenching your teeth during the day?
Yes	No	Have you ever been told that you grind your teeth?
Yes	No	Do you have “tension” headaches?
Yes	No	Have you ever experienced chronic ringing in your ears?
Yes	No	Are you aware that some appointments will be during work hours?

Please describe any additional medical or dental information below.

_____

_____

_____

_____

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ORTHODONTIC EXAMINATION/ BENEFITS

The comprehensive orthodontic exam will include a study of the following: Alignment of the teeth, the bite and jaws as they relate to smiling and overall dental health. For proper diagnosis of malocclusion, measurements are taken from photographs and an x-ray. The photographs reveal how the teeth align with the smile. A digital imaging x-ray, a Cone-Beam, obtained by Dr. Scanlan takes the place of a series of x-rays typically taken by an orthodontist, potentially reducing radiation exposure. The x-ray provides detailed information assisting Dr. Scanlan in making the most accurate diagnosis to form the most concise, efficient and effective treatment plan obtainable. Additionally, the detailed image obtained may reveal some structures more clearly than a regular x-ray. Therefore any pathology outside of the diagnostic realm of orthodontia is not examined by Dr. Scanlan. Once Dr. Scanlan has reviewed the photographs, the x-ray and completes the clinical examine of the teeth and bite, a diagnosis and treatment plan will be discussed. The journey to straight beautiful teeth begins here!

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service providing an improvement in the appearance of the teeth, general function of the teeth and general dental health. Teeth, gums and jaws are an intricate part of the body that may fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout a lifetime and some movement of teeth and some change may occur following treatment. I have read and understand the information provided and I authorize Dr. Scanlan to perform a complete orthodontic evaluation.

Print Name: _____ Signature: _____ Date: _____

AUTHORIZATION OF INFORMATION

I understand that if TS Orthodontics is going to provide financing, credit bureau reports may be obtained. This inquiry does NOT negatively affect your credit as TS Orthodontics is a dental provider. I authorize TS Orthodontics to obtain my credit, if needed.

Print Name: _____ Signature: _____ Date: _____

A B C

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA FORM)

You May Refuse to Sign This Acknowledgement

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

Print Name: _____ Signature: _____ Relationship to patient: _____ Date: _____

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained due to the following:

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

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HIPAA

Operations:

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance, conducting training program accreditation, certification, licensing or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends:

We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care:

We may use or disclose health information to notify or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care of your location, your general conditional or death. If you are present then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your professional judgment disclosing only health information that is directly relevant to person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services:

We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when required to do so by law.

Questions and Complaints:

If you are concerned that we may have violated your privacy rights or 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 you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Service upon request.

We support your right to the privacy of your health information. We will not duplicate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.