TS Orthodontics and Dental Specialists

**PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE**

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_____ Cell phone_____ Carrier_____

Date of Birth_____/_____/_____Social Security #_____Email address_____

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

**RESPONSIBLE PARTY INFORMATION**

Name_____Relationship to Patient_____
Last First Middle

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_____

Email address_____Social Security #_____ Date of Birth___/_____/_____

Marital Status: Single_Married_Widowed_Separated_Divorced_

Employer_____ Occupation_____ No. years employed_____

How would you prefer to be contacted regarding future appointments and office information? ____phone ____email ____text

**SPOUSE INFORMATION**

Spouse's Name_____ Relationship to Patient_____

Social Security # Date of Birth___/____/_____/ Work Phone_____

Employer_____ Occupation_____ No. years employed_____

**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_____

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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 | Is the patient taking any medication? |
| Yes | No | Is the patient allergic to any medication? |
| Yes | No | History of a major illness? |
| Yes | No | Has the patient had any operations? |
| Yes | No | Ever been involved in a serious accident? |
| Yes | No | Has seen a physician in the last 12 months? Why? |

Female Patients only:

| | | |
|---|---|---|
| Yes | No | Menstruation has started? |
| Yes | No | Is the patient pregnant? |

Circle any of the medical conditions below that the patient has had or currently has.

| | | | |
|---|---|---|---|
| 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 | Is the patient presently in any dental pain? |
| Yes | No | Ever experienced any unfavorable reaction to dentistry? |
| Yes | No | Has the patient 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 gums bleed when brushing? |
| Yes | No | Any type of thumb or tongue habit? |
| Yes | No | Is the patient a mouth breather? |
| Yes | No | Has the patient ever seen an orthodontist? If yes, who and when? |
| Yes | No | What is the patient's attitude toward receiving orthodontic treatment? |
| Yes | No | Has anyone in the family received orthodontic treatment? |
| | | How did they feel about the result? |
| Yes | No | Do teeth or jaws ever feel uncomfortable first thing in the morning? |
| Yes | No | Experience jaw clicking or popping? |
| Yes | No | Aware of clenching or grinding teeth during the day? |
| Yes | No | Experience "tension" headaches? |
| Yes | No | Has the patient ever experienced chronic ringing in the ears? |
| Yes | No | Does the patient need extra help with instructions? |
| Yes | No | Is the patient sensitive or self-conscious about his/her teeth? |
| Yes | No | Height of parents? Mom_____ Dad_____ |
| Yes | No | Are you aware that some appointments will be during school hours? |

Please describe any additional medical or dental information below.

_____

_____

_____

_____

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**EMERGENCY INFORMATION**

Name of nearest relative not living with you_____

Complete address_____
Street City Zip

Phone_____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

Print Name: _____ Signature: _____ Date: _____

**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)

**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.