Insight Orthodontics

ORTHODONTIC ADULT PATIENT INFORMATION

PATIENT'S NAME: _____ **NICKNAME**: _____

DATE OF BIRTH: _____ **AGE:** _____

ADDRESS: _____

CITY:_____**ZIP CODE:**_____

CELL PHONE: _____ **CELL PHONE CARRIER:** _____

EMAIL:_____

PREFERRED METHOD OF COMMUNICATION: ___ Text ___ E-Mail ___ Phone

EMPLOYER: _____ **OCCUPATION**: _____

MARITAL STATUS: ___ Single ___ Married ___ Divorced ___ Widowed

Emergency Contact Name: _____

Emergency Contact Phone#: _____ **Relationship:** _____

GENERAL DENTIST: _____

MEDICAL PHYSICIAN : _____ **None** ___

HOW DID YOU HEAR ABOUT US? _____

RESPONSIBLE PARTY: ___ SELF ___ Parent **(Name & DOB)** _____

(Address) _____

Insurance Name_____**Insurance Phone:**_____

Subscriber Name _____**DOB:**_____

SSN or ID: _____**Employer:**_____

Group #:_____

Insight Orthodontics
337 S Rancho Santa Fe Rd San Marcos CA 92078
(760)334-5000 www.insightorthodontics.com

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Patient Name:

What are the main concerns that you would like orthodontics to accomplish?

_____

Have you ever been evaluated or had orthodontic treatment before?	**Yes**	**No**
Have you ever had a serious/difficult problem associated with dental work?	**Yes**	**No**
Have you ever had an injury to your Mouth/Teeth/Chin?	**Yes**	**No**
Do you have any speech problems?	**Yes**	**No**
Do you breath through your mouth?	**Yes**	**No**
Do you have any missing or extra permanent teeth?	**Yes**	**No**
Do you smoke or use tobacco in any form?	**Yes**	**No**
Have you experienced any discomfort in your jaw joint (TMJ/TMD)?	**Yes**	**No**
Have you ever taken any bisphosphonate drugs?	**Yes**	**No**

Have you ever had any of the following medical problems?

Y	**N**	Abnormal Bleeding	**Y**	**N**	Diabetes
Y	**N**	Anemia	**Y**	**N**	Hepatitis
Y	**N**	Artifical Bones/Joints/Valves	**Y**	**N**	High/Low Blood Pressure
Y	**N**	Blood Transfusion	**Y**	**N**	Hospitalized for Any Reason
Y	**N**	Cancer/Chemotherapy	**Y**	**N**	Kidney Problems
Y	**N**	Congenital Heart Defect	**Y**	**N**	Mitral Valve Prolapse
Y	**N**	Diabetes	**Y**	**N**	Psychiatric Problems
Y	**N**	Difficulty Breathing	**Y**	**N**	Radiation Treatment
Y	**N**	Drug/Alcohol Abuse	**Y**	**N**	Rheumatic/Scarlet Fever
Y	**N**	Emphysema	**Y**	**N**	Severe/Frequent Headaches
Y	**N**	Epilepsy/Seizures/Fainting	**Y**	**N**	Shingles
Y	**N**	Fever Blisters/Herpes	**Y**	**N**	Sickle Cell Disease/Traits
Y	**N**	Glaucoma	**Y**	**N**	Sinus Problems
Y	**N**	Heart Attack/Stroke	**Y**	**N**	Tuberculosis (TB)
Y	**N**	Heart Murmur	**Y**	**N**	Ulcers/Colitis
Y	**N**	Heart Surgery/Pacemaker	**Y**	**N**	Venereal Disease

Are you allergic to any of the following?

Y	**N**	Aspirin	**Y**	**N**	Dental Anesthetics
Y	**N**	Penicillin	**Y**	**N**	Any Metals/Plastics
Y	**N**	Erythromycin	**Y**	**N**	Tetracycline
Y	**N**	Codeine	**Y**	**N**	Latex
Y	**N**	Other _____			

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature **Date**

Doctor Signature: _____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Signature: _____ **Date:** _____

Relationship to patient: _____

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