PATIENT INFORMATION

PATIENT NAME____

First Middle Last

Gender_____ DOB_________________ Home Phone (_____)___________ - ___________________________________

Home Address____

Street City State Zip

Cell # (_____) _________________ Cell Phone Carrier____________________ Email ___________________________

Referred By________________________ Patient's Dentist____

Who noticed the orthodontic concern? Patient______ Patient's Dentist____________________ Other______________

Describe what concerns you most about orthodontic treatment?____

Employer________________________ Occupation_________________________ Work# (____)_________-__________

Business Address____

Street City State Zip

Hobbies/Interest____

Family Information

Spouse/Partner____

First Middle Last

Cell # (_____) _________________ Carrier_______________ Email____

Employer________________________ Occupation_____________________ Work # (______)_____________________

Business Address____

Street City State Zip

Emergency Contact

Name____

First Middle Last

Relationship__________________________________ Cell # (_____) _________________________________

Welcome to ORTHOSTYLE by Dr. Mina! Please complete this form as accurately as possible. It is important for us to have this information in order to provide the best possible care for your child. Your privacy is important to us. The information you share with us will remain strictly confidential.

ADULT MEDICAL HISTORY

Physician's Name____________________________Address____Phone___________________

Are you currently taking any medications? □ YES □ NO List: ____
Are you allergic to any medications? □YES □ NO List:____
Any major changes in your health recently? □YES □ NO List:____
Have your tonsils or adenoids been removed? □YES □ NO List:____

Please check if you have had any of the following conditions:

AIDS/HIV	□YES □ NO	Growth Disorders	□ YES □ NO	Prone to ear infections	□ YES □ NO
Anemia	□YES □ NO	Heart Condition	□ YES □ NO	Prone to sore throats	□ YES □ NO
Asthma	□YES □ NO	Heart Murmur	□ YES □ NO	Prolonged Bleeding	□ YES □ NO
Hearing Impaired	□ YES □ NO	Psychiatric Care	□ YES □ NO		
Bone Disorder	□YES □ NO	Hepatitis Type	□ YES □ NO	Rheumatic Fever	□ YES □ NO
Blood Disease	□YES □ NO	Hernia Repair	□ YES □ NO	Seizures	□ YES □ NO
Bronchitis	□YES □ NO	Herpes/Cold Sores	□ YES □ NO	Sinus Trouble	□ YES □ NO
Cancer	□YES □ NO	Hives/Rash	□ YES □ NO	Tonsillitis	□ YES □ NO
Developmental Disorder	□ YES□ NO	Kidney Disorder	□ YES □ NO	Trauma to face or jaw	□ YES □ NO
Diabetes Type	□YES □ NO	Latex Allergy	□ YES □ NO	Tuberculosis	□ YES □ NO
Dizziness or Fainting	□ YES □NO	Latex Sensitive	□ YES □ NO	Ulcer	□ YES □ NO
Emotional Problems	□YES □ NO	Liver Disorder	□ YES □ NO	Vertigo	□ YES □ NO
Endocrine	□ YES □NO	Mouth Breather	□ YES □ NO	Vision Impaired	□ YES □ NO
Epilepsy	□YES □ NO	Mitral Valve Prolapse	□ YES □ NO	Other:	
Facial Jaw/TMJ Pain	□ YES □NO	Nervous/Anxious	□ YES □ NO		
Frequent Headaches	□ YES □NO	Prone to colds	□ YES □ NO		

Are there any other conditions or concerns that you think we should know about?

DENTAL HISTORY

Dentist's Name______________________________Address____Phone______________________

Frequency of dental checks: □ Every_____Months □ Only if problem exists □ Never Date of last visit_______________

Any unfinished care to be completed by dentist? □YES □ NO Explain:____
Any facial or dental injuries? □ YES □ NO Explain:____
Are you nervous about dental treatment? □YES □ NO Explain:____
Have you had an unpleasant experience? □YES □ NO Explain:____
Do you play a musical instrument? □YES □ NO Which:____
Any changes to your bite or dental alignment? □YES □ NO Explain:____
Any previous orthodontic treatment? □YES □ NO With whom?____
Are you satisfied with previous treatment? □YES □ NO Explain:____
What are the chief concerns you have related to the position of your teeth or bite?
□Aesthetic □Cleaning □Comfort □Ability to chew □Stability
Please elaborate:____

Please check if there is a history of:
□ Clenching teeth □Grinding teeth □Jaw joint clicking □Jaw joint soreness □Jaw joint popping □Ringing in the ears
□Headaches (more than normal) □Mouth breathing □Awake □Asleep □Muscular soreness around the head and neck
Speech Problems □ YES □ NO Explain:____
Any other information that may be helpful?____

Patient's Signature____DATE___________ Reviewed by____________________________

ORTHOSTYLE
BY DR. MINA

Financial Responsibility

Who is financially responsible for this account? ____

Home address (or reference one above)____

Home Phone(_____)______ -_________ Cell#(_____)______ -_________ Email___________________________

Social Security #________________________________Employer___________________________

Dental Insurance Information

Primary policy holder's full name_____________________ Birth date________________________

Social Security #_____________________Relationship to patient ________________________

Address and phone (if not listed above)____

Employer________________________Address____

Insurance company____________________________ Group #________________ID#______________

Does this policy have orthodontic benefits? O Yes O No O Don't Know

Secondary policy holder's full name___________________ Birth date________________________

Social Security #_____________________Relationship to patient ___________________________

Address and phone (if not listed above)____

Employer________________________Address____

Insurance company____________________________ Group #________________ID#______________

Does this policy have orthodontic benefits? O Yes O No O Don't Know

ORTHO**STYLE**
BY DR. MINA

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Orthostyle by Dr. Mina. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for service, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility and available upon request.

Orthostyle by Dr. Mina reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY		**YES**		**NO**
SPOUSE ONLY		**YES**		**NO**
OTHER (please specify)		**YES**		**NO**

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgment not obtained					
PROVIDED PRIOR TO TREATMENT?		**YES**		**NO**	
DATE PROVIDED:					
REASON FOR DENIAL:		NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES			
		WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING			
		UNABLE TO SIGN			
		REASON NOT GIVEN			
		OTHER (EXPLAIN):			