North Portland Orthodontics

Date:_____

Welcome to Our Office!

ADULT PATIENT INFORMATION

Patient's name:_____ Sex: (M) (F) Nickname:_____
Address:_____ City:_____ State:_____ Zip:_____
Birthdate:_____ Age:_____ Home Phone:_____ Social Security #:_____
Email:_____ Cell Phone #:_____
Cell Phone Carrier:_____ Text Appt. Confirmations?: **Y N**
Employer:_____ Position:_____ Years:_____
Whom may we thank for referring you to our office?_____

DENTAL INSURANCE INFORMATION

1. Subscriber's Name:_____
Social Security #/ ID #:_____
Subscriber's DOB:_____ Group #:_____
Insurance Company:_____
Insurance Address:_____
Phone:_____
Do you have dual coverage? Yes___ No___

2.Subscriber's Name:_____
Social Security #/ ID #:_____
Subscriber's DOB:_____ Group #:_____
Insurance Company:_____
Insurance Address:_____
Phone:_____
If dual coverage, which is primary?_____

1.Office Use Only:
*Ortho benefits amount*_____ *Paid at*_____ *Qtrly Mnthly Yrly Any used? Y N*

2.Office Use Only:
*Ortho benefits amount*_____ *Paid at*_____ *Qtrly Mnthly Yrly Any used? Y N*

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you:_____
Phone:_____ Relationship to Patient:_____

MEDICAL HISTORY

Patient's Name:_____ Patient's Date of Birth:_____
Physician:_____ Date of Last Visit:_____
Address:_____ Phone:_____

Yes	No	
☐	☐	**Are you allergic to any medication?_____**
☐	☐	**Have you had any operations?_____**
☐	☐	**Ever been involved in a serious accident?_____**
☐	☐	**Have you seen a physician in the last 12 months? Why?_____**
☐	☐	**Latex Allergy?_____**

Please circle any of the following conditions that apply to our patient now, or in the past.

Abnormal	**Chemotherapy**	**Heart Problems**	**Nervous Disorders**	**Tuberculosis**
Bleeding/Hemophilia	**Congenital heart Defect**	**Heart Murmur**	**Pneumonia**	**Tumor/Cancer**
Anemia	**Diabetes**	**hepatitis/Liver Problems**	**Pregnancy**	
Arthritis	**Dizziness**	**High Blood Pressure**	**Prolonged Bleeding**	**Other:_____**
Asthma or Hay fever	**Epilepsy**	**HIV/Aids**	**Radiation therapy**	**_____**
Bone Disorders	**Gastrointestinal Disorders**	**Kidney Problems**	**Rheumatic Fever**	

DENTAL HISTORY

General Dentist:_____ Date of last visit:_____

Yes	No	
☐	☐	Are you presently in any dental pain?
☐	☐	Ever experienced any unfavorable reaction to dentistry?
☐	☐	Have you ever lost or chipped any teeth?
☐	☐	Have there ever been any injuries to face, mouth, or teeth?
☐	☐	Is any part of your mouth sensitive to temperature or pressure? Where?_____
☐	☐	Do your gums bleed when brushing?
☐	☐	Do you have any type of thumb or tongue habit?
☐	☐	Do your teeth or jaws ever feel uncomfortable first thing in the morning?
☐	☐	Experience jaw clicking or popping?
☐	☐	Aware of clenching or grinding teeth during the day?
☐	☐	Experience "tension" headaches?
☐	☐	Have you ever experienced chronic ringing in the ears?

ORTHODONTIC GOALS

What concerns you most about your teeth?_____

Yes	No	
☐	☐	Have you ever seen an orthodontist? If yes, who and when?_____
☐	☐	Has anyone in the family received orthodontic treatment?_____
		Orthodontic treatment can, to some extent, alter facial appearance.
☐	☐	Are you sensitive or self-conscious about your teeth?
☐	☐	Are you sensitive or self-conscious about your facial appearance?

I attest to the accuracy of this information and acknowledge that it is my responsibility to notify this office of any medical or contact changes; I authorize release of any information to a third party for insurance claims, education, and/or treatment; I understand that a credit bureau check may be obtained where necessary.

Patient Signature:_____

Notice of Privacy Acts Consent Form

I understand that I have certain rights given to me under the Health Insurance Portability and Accountability Act (HIPPA) regarding my protected health information. I understand that by signing this consent form, I authorize you to use and disclose my protected health information for the following:

- Treatment including that given by all health care providers involved in my care.

- Obtaining payment from third party payers including insurance companies and other paying parties.

-The day-to-day health care practices of the orthodontic practice.

I have also been informed that I may request a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy or the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may ask that this consent be revoked but I must do so in writing. However, any use or disclosure that occurred prior to the date is not affected.

Patient Name:_____

Signature:_____

Date:_____

Date:	**Initials:**	**Reason:**