ADULT ORTHODONTIC ACQUAINTANCE CARD

DATE_____20_____

DATE OF BIRTH_____

PATIENT'S NAME_____AGE_____SEX_____

LAST FIRST INITIAL

ADDRESS_____ZIP_____TEL (H) _____(C) _____

PATIENT'S DENTIST_____REFERRED BY_____

PHYSICIAN_____PATIENT'S ORAL SURGEON_____

OCCUPATION_____EMPLOYED BY_____

BUSINESS ADDRESS_____BUSINESS TELEPHONE_____

RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE_____

RESP PARTY ADDRESS_____TEL (H) _____(C) _____

EMPLOYED BY_____

BUSINESS ADDRESS_____BUSINESS TELEPHONE_____

DO YOU HAVE DENTAL INSURANCE? _____ORTHODONTIC COVERAGE? _____

DENTAL INSURANCE PROGRAM_____GROUP#_____CERTIFICATE#_____

SUBSCRIBER NAME_____

SUBSCRIBER SSN_____SUBSCRIBER DATE OF BIRTH_____

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MEDICAL HISTORY

	YES	NO
IS PATIENT IN GOOD HEALTH? _____	Y	N
DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____	Y	N
IS PATIENT UNDER A PHYSICIAN'S CARE NOW? _____	Y	N

IF YES, REASON: _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, AND GIVE REASONS_____

ARE YOU AWARE OF ANY OF THE FOLLOWING MEDICAL CONDITIONS? PLEASE CHECK:

HEART CONDITION ☐ RHEUMATIC FEVER ☐ DIABETES ☐ EPILEPSY ☐

HEPATITIS/LIVER PROBLEM ☐ SURGERY OF HEAD/ NECK ☐ EXCESSIVE BLEEDING ☐ GROWTH PROBLEMS ☐

DRUG REACTIONS ☐ ALLERGIES ☐ TUBERCULOSIS ☐ TONSILS OR ADENOID REMOVAL ☐

DOES PATIENT HAVE TENDENCY TO: COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐ SINUS PROBLEMS ☐

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DENTAL HISTORY

	YES	NO
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____	Y	N
DOES THE PATIENT HAVE ANY SPEECH CONCERNS? _____	Y	N
IS THE PATIENT A MOUTH BREATHER? _____ WHILE AWAKE? _____WHILE ASLEEP? _____	Y	N
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____	Y	N
ARE YOU AWARE OF YOUR JAW CLICKING OR POPPING? _____	Y	N
HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____	Y	N
HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____	Y	N
DOES PATIENT VOMIT, GAG OR FAINT EASILY? _____	Y	N
ANY PAIN IN OR NEAR THE EARS? RIGHT? _____LEFT? _____	Y	N

LAST VISIT TO A DENTIST? _____

WHAT WOULD YOU WISH TO GAIN BY ORTHODONTIC TREATMENT? _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

AUTHORIZATION AND OFFICE POLICY

*I authorize and request my insurance company to pay my insurance benefits directly to MIDCOAST ORTHODONTICS.

*I understand that my dental insurance carrier may pay less than the actual bill for services, and I am responsible for the portion of the bill which the insurance company does not cover.

*We want you to get the maximum benefit from your dental insurance. We will file the appropriate initial claims throughout your treatment. If you are unsatisfied with the benefits provided by your insurance company, it is your responsibility to file all claim resubmissions and mediate with your insurance provider.

*I agree to be responsible for payments of all services rendered on my behalf or my dependents.

*Any account balance sixty (60) days past due will be assessed a finance charge of 1.5% per month.

*I understand it may be necessary to schedule some orthodontic appointments during school or work hours.

SIGN HERE_____DATE_____

Signature of Patient or Responsible Party if minor

NOTICE OF PRIVACY PRACTICES – HIPPA

Disclosure of Health Information

We may use and disclose health information about you/your child for treatment, payment, and coordination of healthcare with other providers. We may disclose your/your child's information to another healthcare provider. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to anyone besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your/your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information. If you request copies we will charge you for each page for staff time to locate and copy the information, and postage if you want the copies mailed.

Restriction: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of information.

Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means.

Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about your access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the U.S. Department of Health and Human Services. If you have any further questions about our privacy practices, please ask us for clarification.

Signature_____ Date_____