Dearing & Jones Orthodontics

SPECIALISTS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

Welcome to Our Practice!

Today's Date: _____

Patient: _____ DOB: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address (if different from above) _____

Home #: _____ Cell #: _____ Work #: _____

SSN (if over 18): _____ **Dentist:** _____

Parent/Guardian accompanying patient (if patient is a minor)

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Sex: _____ DOB: _____ SSN: _____

Consent for Release of Patient Information

Please be sure to include anyone who may bring your child to his/her appointment, may call to check an appointment time, call to reschedule/cancel an appointment, request a balance, change auto-draft information, discuss treatment, discuss insurance, or any other matter that may arise.

I, _____, hereby authorize the doctors and staff of Dearing & Jones Orthodontics to release records and knowledge concerning my/my child's dental health and/or financial and insurance information pertaining to the orthodontic treatment to the following person(s):

Name	*Relationship*	*Financials Yes/No*

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Signature: _____ Date: _____

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Dental History:

Please circle "Yes" or "No" to indicate if you have or have had any of the following:

Jaw Pain	Y	N	Gums Swollen/Tender	Y	N
Jaw Popping/Clicking	Y	N	Grinding Teeth	Y	N
Bleeding Gums	Y	N	Teeth Sensitivity (Hot/Cold)	Y	N
Blisters on Lips/Mouth	Y	N	Mouth Breather	Y	N
Chew on Side of Mouth	Y	N	How often do you brush? _____		
Tobacco Use	Y	N	How often do you floss? _____		

Medical History

Please circle "Yes" or "No" to indicate if you have or have had any of the following:

AIDS	Y	N			
Anemia	Y	N	Emphysema	Y	N
Angina/Chest Pain	Y	N	Epilepsy/Seizures	Y	N
Artificial Heart Valve	Y	N	Fainting/Dizziness	Y	N
Artificial Joint	Y	N	Heart Murmur	Y	N
Asthma	Y	N	Heart Problems	Y	N
Bleeding abnormally			Hemophilia	Y	N
with extractions/surgery	Y	N	Hepatitis Type _____	Y	N
Blood Disease	Y	N	Herpes	Y	N
Blood Transfusion	Y	N	High Blood Pressure	Y	N
Cancer	Y	N	HIV +	Y	N
Chemical Dependency	Y	N	Kidney Disease	Y	N
Circulatory Problems	Y	N	Leukemia	Y	N
Cirrhosis	Y	N	Low Blood Pressure	Y	N
Congenital Heart Lesion	Y	N	Mitral Valve Prolapse	Y	N
Diabetes Type _____	Y	N	Prosthetic Replacement	Y	N
Dialysis	Y	N	Radiation Treatment	Y	N
Drug Use	Y	N	Respiratory Treatment	Y	N
			Rheumatic Fever	Y	N

Women Only: Are you pregnant? Yes No

Medications: _____

_____

Other Medical Conditions: _____

Allergies (including medications: _____

_____

Do you need or have you ever taken prophylaxis (antibiotics) prior to treatment of any kind?
If yes, please mark and notify the doctor during the examination* **YES** **NO**

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform the office of any medical, address, or insurance changes, etc.

Signature: _____ Date: _____

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Appointment Reminder:

As a service to our patients, we provide a courtesy reminder call, text, and/or email and possibly other important calls that may be placed using a prerecorded message.

Would you like to participate in our courtesy reminder service? (circle one) **YES*** **NO**

***If yes, please provide the requested information:**

Name of Responsible Party: _____

Cell Phone: _____ Email: _____

I agree that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for the treatment of a minor child.

I accept full financial responsibility for all charges not covered by insurance.

Signature: _____ Date: _____

HIPAA Notice (Health Insurance Portability & Accountability Act)

Acknowledgement of Receipt of Privacy Practices – **Dearing & Jones Orthodontics**

I have received & reviewed the Notice of Privacy Practices for this office (laminated back page).

A copy is available upon request.

You may refuse to sign this acknowledgement
(if refused we will be unable to provide any treatment)

Print Name: _____

Signature: _____ Date: _____

****FOR OFFICE USE ONLY****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): _____