COA
Creative Orthodontic Associates

ADULT PATIENT INFORMATION

Patient Information

Last Name _____ First _____ MI _____

Sex _____ Age _____ Birthdate _____

Home Address _____

City _____ State _____ Zip code _____

Occupation _____ Name of Employer _____

Business Address _____

City _____ State _____ Zip code _____

Home Phone # _____ Business Phone # _____

Cell Phone # _____ E-Mail _____

Social Security # _____

Have you had any trauma to jaws or teeth? _____

Do you have clicking or pain in the jaw joints; facial pain, clenching, tooth grinding, etc? ◯ Yes ◯ No

If so, for how long? Please explain fully: _____

Do your teeth come together evenly? ◯ Yes ◯ No

Are you aware of any dental or periodontal problems? ◯ Yes ◯ No

if so please explain fully: _____

What is the reason for coming to our office? _____

Have you had any previous orthodontic evaluation or treatment? ◯ Yes ◯ No

Are you interested in cosmetic braces, clear braces or invisible braces? _____

Is there any additional information that would be helpful in your evaluation and treatment? ◯ Yes ◯ No

if so please explain fully: _____

Name of Doctor who referred you to our office _____

If not a Doctor, where did you hear about our office? _____

Family Dentist _____ Date of last visit _____ Physician _____

Which is the best telephone number to reach you? _____

What is the best way to confirm your appointments? ◯ Telephone ◯ Text ◯ E-Mail

In case of emergency please contact _____

Phone Number _____ Relation to patient _____

Children Information

Name _____ Birthdate _____ Age _____ ◯ M ◯ F

Name _____ Birthdate _____ Age _____ ◯ M ◯ F

Name _____ Birthdate _____ Age _____ ◯ M ◯ F

Dental Insurance Information

Primary Carrier _____

Company name _____

Address _____

City _____ State _____ Zip Code _____

Telephone # _____

Name of the insured _____

Social Security # of insured _____

Birthdate of Insured _____

Relationship of patient to insured _____

Policy # _____ Group # _____

Effective Date of Policy _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
I understand that I am responsible for all costs of dental treatment.

Date: _____

SIGNATURE (PATIENT OR PARENTS If MINOR)

Secondary Carrier _____

Company name _____

Address _____

City _____ State _____ Zip Code _____

Telephone # _____

Name of the insured _____

Social Security # of insured _____

Birthdate of Insured _____

Relationship of patient to insured _____

Policy # _____ Group # _____

Effective Date of Policy _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
I understand that I am responsible for all costs of dental treatment.

Date: _____

SIGNATURE (INSURED PERSON)

A PHOTOCOPY OF MY SIGNATURE SHALL SERVE AS AN ORIGINAL FOR INSURANCE PURPOSES (“SIGNATURE ON FILE”)

THE INFORMATION ON THE FRONT AND BACK OF THIS PAGE IS CORRECT.

SIGNATURE

Signature of Parent/Guardian

Date: _____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.c., individually identifiable information, such as names, dates, phone/fax numbers, e-mail addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., The American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by the other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person to direct your questions to this person at our office address. Thank you

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Date: _____

Patient

Health History Form

Email _____ Today's Date: _____

American Dental Association
www.ada.org

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please Note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE)

Home Phone: _____ (INCLUDE AREA CODE) Business/Cell Phone: _____ (INCLUDE AREA CODE)

Address: _____ (MAILING ADDRESS) City _____ State _____ Zip: _____

Occupation: _____ Height: _____ Weight: _____ Date of birth: _____ Sex: ◯ M ◯ F

SS# or Patient ID : _____ Emergency Contact : _____ Relationship : _____

Home Phone: _____ (INCLUDE AREA CODES) Cell Phone: _____ (INCLUDE AREA CODES)

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the question)	**Yes**	**No**	**DK**
Active Tuberculosis	◯	◯	◯
Persistent cough greater than a 3 week duration	◯	◯	◯
Cough that produces blood	◯	◯	◯
Been exposed to anyone with Tuberculosis	◯	◯	◯

If you answer Yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following question, please select your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	◯	◯	◯
Are your teeth sensitive to cold, hot. sweets or pressure?	◯	◯	◯
Does food or floss catch between your teeth?	◯	◯	◯
Is your mouth dry?	◯	◯	◯
Have you had any periodontal (gum) treatments?	◯	◯	◯
Have you ever had orthodontic (braces) treatment?	◯	◯	◯
Have you had any problems associated with previous dental treatment?	◯	◯	◯
Is your home water supply fluoridated?	◯	◯	◯
Do you drink bottled or filtered water ? If Yes, how often?	◯	◯	◯
Circle one: ◯ DAILY ◯ WEEKLY ◯ OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	◯	◯	◯

	Yes	**No**	**DK**
Do you have earaches or neck pains?	◯	◯	◯
Do you have any clicking, popping or discomfort in the jaw?	◯	◯	◯
Do you brux or grind your teeth?	◯	◯	◯
Do you have sores or ulcers in your mouth?	◯	◯	◯
Do you wear dentures or partials?	◯	◯	◯
Do you participate in active recreational activities?	◯	◯	◯
Have you ever had a serious injury to your head or mouth?	◯	◯	◯

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental X-rays: _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Medical Information *Please select your response to indicate if you have or have not any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	◯	◯	◯
Are you in good health?	◯	◯	◯
Has there been any change in your general health within the past year?	◯	◯	◯

Physician Name: _____

Phone: _____ (INCLUDE AREA CODE)

Address/City/State/Zip: _____

_____

_____

If yes, what condition is being treated? _____

Date of last physical exam _____

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	◯	◯	◯
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	◯	◯	◯

If yes, what was the illness or problem? _____

_____

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information *Please select your response to indicate if you have or have not any of the following diseases or problems.*

(Check DK If You Don't Know The Answer To The Question)

	Yes	No	DK
Do you wear contact lenses?	○	○	○
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	○	○	○
Date _____			
If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosama ®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	○	○	○
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredi® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	○	○	○
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	○	○	○
Do you use tobacco (smoking, snuff, chew, bidis)?	○	○	○
If so, how interested are you in stopping?			
(Circle one) ○ VERY ○ SOMEWHAT ○ NOT INTERESTED			
Do you drink alcoholic beverages?	○	○	○
If Yes, how much alcohol did you drink in the last 24 hours? _____			
If Yes, how much do you typically drink In a week? _____			

WOMEN ONLY Are you:

Pregnant?	○	○	○
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	○	○	○
Nursing?	○	○	○

Allergies - Are you allergic to or have you had a reaction to

To all **Yes** responses, specify type of reaction

	Yes	No	DK
Local anesthetics _____	○	○	○
Aspirin _____	○	○	○
Penicillin or other antibiotics _____	○	○	○
Barbiturates, sedatives, or sleeping pills _____	○	○	○
Sulfa drugs _____	○	○	○
Codeine or other narcotics _____	○	○	○
Metals _____	○	○	○
Latex (rubber) _____	○	○	○
Iodine _____	○	○	○
Hay fever/seasonal _____	○	○	○
Animals _____	○	○	○
Food _____	○	○	○
Other _____	○	○	○

Please select your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial(prosthetic) heart valve	○	○	○
Previous infective endocarditis	○	○	○
Damaged valves in transplanted heart	○	○	○
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	○	○	○
Repaired(completely) in last 6 months	○	○	○
Repaired CHD with residual defects	○	○	○

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD,

	Yes	No	DK
Cardiovascular disease	○	○	○
Angina	○	○	○
Arteriosclerosis	○	○	○
Congestive heart failure	○	○	○
Damaged heart valves	○	○	○
Heart attack	○	○	○
Heart murmur	○	○	○
Low blood pressure	○	○	○
High blood pressure	○	○	○
Other congenital heart defects	○	○	○
Mitral valve prolapse	○	○	○
Pacemaker	○	○	○
Rheumatic fever	○	○	○
Rheumatic heart disease	○	○	○
Abnormal bleeding	○	○	○
Anemia	○	○	○
Blood transfusion	○	○	○
If Yes, date: _____			
Hemophilia	○	○	○
AIDS or HIV infection	○	○	○
Arthritis	○	○	○

	Yes	No	DK
Autoimmune disease	○	○	○
Rheumatoid arthritis	○	○	○
Systemic lupus erythematosus	○	○	○
Asthma	○	○	○
Bronchitis	○	○	○
Hepatitis, jaundice or liver diseases	○	○	○
Epilepsy	○	○	○
Fainting spells or seizures	○	○	○
Neurological disorders	○	○	○
If Yes, specify _____			

Emphysema	○	○	○	Sleep Disorder	○ ○ ○
Sinus trouble	○	○	○	Mental health disorders	○ ○ ○
Tuberculosis	○	○	○	Specify: _____	
Cancer/ Chemotherapy	○	○	○	Recurrent infections	○ ○ ○
Radiation Treatment	○	○	○	Type of infection _____	
Chest pain upon exertion	○	○	○	Kidney problems	○ ○ ○
Chronic pain	○	○	○	Night sweats	○ ○ ○
Diabetes Types I or II	○	○	○	Osteoporosis	○ ○ ○
Eating disorder	○	○	○	Persistent swollen glands in neck	○ ○ ○
Malnutrition	○	○	○	Severe headaches/ migraines	○ ○ ○
Gastrointestinal disease	○	○	○	Severe of rapid weight loss	○ ○ ○
G.E. Reflux/ persistent Heartburn	○	○	○	Sexually transmitted disease	○ ○ ○
Ulcers	○	○	○	Excessive urination	○ ○ ○
Thyroid problems	○	○	○		
Stroke	○	○	○		
Glaucoma	○	○	○		

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ○ ○ ○

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ○ ○ ○

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____