SUMMIT FAMILY ORTHODONTICS

DATE: _____

PATIENT INFORMATION:

Patients Name: _____ Preferred Name: _____

Date of Birth: _____ If patient is minor, please give parent/guardian's name: _____

Dentist: _____

RESPONSIBLE PARTY INFORMTATION:

Relationship to Patient: _____

Name: _____ Marital Status: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Number: _____ Mobile Number: _____ Work Number: _____

Email Address: _____ Social Security #: _____ Birth Date: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Relationship to Patient: _____

Spouse's Employer: _____ Occupation: _____

Spouse's Mobile Number: _____ Birth Date: _____ Social Security #: _____

DENTAL INSURANCE INFORMATION:

Insured's Name: _____ DOB: _____ ID/Social Security #: _____

Insurance Company Name: _____ Insurance Phone #: _____

Group #: _____ Insured's Employer: _____

Do you have dual coverage? YES NO If yes, please provide the same information as above: _____

_____

_____

EMERGENCY CONTACT:

Name of nearest relative not living with you _____ Phone _____H M W

Address _____ City _____ State _____ Zip _____

How did you hear about our office? ☐ Patient _____ ☐ Summit Family Employee_____
☐ Saw Building ☐ Event_____ ☐ Advertisement_____ ☐ Our Website ☐ Yelp
☐ Insurance Website ☐ Social Media ☐ Other (please specify)_____

SUMMIT FAMILY ORTHODONTICS

Medical/Dental

Information Release Form (HIPAA Release Form)

Name: _____ DOB: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren):_____

[ ] Other_____

[ ] Information should not be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Contact Information

[ ] I authorize Summit Family Orthodontics to contact me at the phone numbers, emails, and any additional contact information provided to the office.

Acknowledgment of Receipt of Notice of Privacy Practice

I acknowledge that I have been presented a copy of Summit Family Orthodontics Notice of Privacy Practices, which has an active date 9/22/2013, and which describes how my health information may be used and disclosed. (Copies available in office and online)

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges the authorization of the release of information, the authorization for leaving voice mail, and that I have been presented with a copy of the Notice of Privacy Practices:

Patient: _____ Date: _____/____/_____

Parent/Legal Guardian: _____ Date: _____/____/_____

Witness: _____ Date: _____/____/_____

SUMMIT FAMILY ORTHODONTICS

Multimedia Publicity/Privacy Release

I hereby grant Summit Family Orthodontics permission to use, reproduce, distribute, publicly perform and display, in any form now known or later developed, the Materials specified in this release throughout the world, for the purpose of advertising and promoting business.

This permission and release is for the following Materials:

- Name
- Voice
- Visual likeness (on photographs, video, film, website, etc.);
- Photographs
- Film, videotape or other audiovisual materials

I release Summit Family Orthodontics, its agents, employees, owners, investors, licensees and assigns from any and all claims I may have now or in the future for invasion of privacy, right of publicity, copyright infringement, defamation or any other cause of action arising out of the use, reproduction, adaptation, distribution, broadcast, performance or display of the Works.

I waive any right to inspect or approve any Works that may be created containing the Materials. I understand and agree that Summit Family Orthodontics is and shall be the exclusive owner of all right, title, and interest, including copyright, in the Works, and any advertising or promotional materials containing the Material released hereunder.

I have read this release. I am fully familiar with its contents, and hereby agree to the terms hereof as of the date indicated below:

Patient Name: _____ Parent/Guardian Name: _____

Signature: _____

Date: _____

SUMMIT FAMILY ORTHODONTICS

HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

Please check all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Abnormal Bleeding
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Persistent Cough
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Headaches
- ☐ Jaw Pain
- ☐ Jaw Popping
- ☐ Limited Mouth Opening
- ☐ Ringing Ears
- ☐ Posture Problems
- ☐ Clenching
- ☐ Grinding
- ☐ Facial Pain
- ☐ Neck Ache
- ☐ Pregnancy
- ☐ Heart Problems: _____ _____
- ☐ Neurological Problems: _____ _____
- ☐ Artificial Joints: _____ _____
- ☐ Tumors: _____ _____
- ☐ Cancer: _____ _____
- ☐ Any other Medical Problems:_____ _____ _____ _____

Please list **ALL** current medications with dosages:

_____

_____

_____

Please list **ALL** know allergies:

_____

_____

Have you ever taken or currently taking medications for osteoporosis or cancer (bisphosphonates)? Ex. Fosamax, Actonel, or Boniva.

- ○ No
- ○ Yes

If yes, please specify: _____

How long were you taking the medication:

_____

If you are currently not taking the medication, when did you stop taking it? _____

Are you currently being monitored by a heath care physician? ___yes ___no

Name of office(s) or doctor(s):

_____

Have you ever experience TMJ pain, soreness, popping, clicking? _____

Have you ever seen any of the following professionals? ENT, Neurologist, Chiropractor, or Massage Therapist._____

Do you have sleep apnea, snore, use a CPAP, or have had a sleep study? _____

Do you have speech problems? ___Yes ___No

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Health History

Patient Name: _____ **Date:** _____

Have you ever sucked your thumb or fingers?

___Yes ___ No

If yes, until what age: _____

Do you breathe through your mouth while awake?

___Yes ___No

While asleep? ___Yes ___No

Have you ever injured your face or jaw?

___Yes ___No

How long ago was the injury: _____

The information I have given is correct to the best of my knowledge. I understand that I must inform the office of any changes to my medical status.

Signature: _____

Date: _____