# Reading Orthodontics

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## Personal History Form

Name First _____ MI ____ Last _____ D.O.B. _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Physician _____ Dentist _____ Referred by _____
Occupation _____ Employed by _____
Business Address _____ Phone _____ EXT ____
Marital Status _____ Spouse's Name _____ No. of Children and Ages _____
Spouse's Occupation _____ Employed by _____
Spouse's Business Address _____ Phone _____ EXT ____
Person Financially Responsible _____ Relationship _____
Dental Insurance: YES NO Orthodontic Coverage: YES NO
Plan Name _____ Subscriber's SS# _____ D.O.B _____ Group # _____

## Medical History

(Please circle yes or no and fill in blanks where required)

1. Date of last medical exam _____ Are you in good health? YES NO
2. Have your tonsils and/or adenoids been removed? At what age? _____ YES NO
3. Any history of major illness? If yes please list _____ YES NO
4. Any allergy or drug sensitivity? If yes please list _____ YES NO
5. Taking any medication now/ If yes please list _____ YES NO
6. Are you under medical and/or psychological care now? Explain _____ YES NO
7. Circle any of the following for which you have or are being treated:

| | | | | |
|---|---|---|---|---|
| Diabetes | Hepatitis | Pos. HIV Antibody | Heart Trouble | Drug Addiction |
| Arthritis | Cancer | Nervous Disorders | Brain injury | Blood Transfusion |
| Asthma | Herpes | Endocrine Problems | Tuberculosis | Rheumatic Fever |
| AIDS | Epilepsy | Thyroid Problems | Infectious Mono | Prolonged Bleeding |
| Tonsillitis | ARC | High Blood Pressure | Pregnancy | Low Blood Pressure |

8. Do you have, or have you ever had any medical condition not mentioned above? YES NO

## Dental History

1. Are you in good dental health? YES NO
2. Date of last dental exam _____ Full mouth X-rays taken? When? _____ YES NO
3. Have you had any injuries to your face, mouth or teeth? Describe _____ YES NO
4. Any oral habits such as lip biting, tongue thrusting or finger sucking? YES NO
5. Have you ever had speech problems or speech therapy? YES NO
6. Are you a mouth breather while asleep or awake? YES NO
7. Are you aware of any missing or extra permanent teeth? YES NO
8. Have you ever had pain, clicking or popping of the jaw joints? Any TMJ Problems? YES NO
9. Do you grind (Brux) your teeth? YES NO
10. Have you ever seen an Orthodontist? If so Dr.'s name _____ Records taken? YES NO
11. Have any members of your family had orthodontic treatment? YES NO
12. Are you overly sensitive to dental pain? YES NO
13. Do you play a wind or reed musical instrument? YES NO
14. What orthodontic problems are you most concerned about? _____
15. What problem is your dentist most concerned about? _____

Person filling out this form please sign: Signature: _____ Date: _____

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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

_____
(PATIENT NAME)

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations for the patient named on this consent

We reserve the right to change our privacy practices as described in our **Notice of Privacy Practices.** If we change our privacy practices, we will issue a revised document. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting our office.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took before we received your written notice. We may decline to treat or continue treating you if revoke this Consent.

I have had full opportunity to read and consider the contents of this **Consent Form** and **Notice of Privacy Practices**. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations for the patient named on this form.

_____ _____
SIGNED (PATIENT OR PARENT IF MINOR) DATE

**You are entitled to a copy of this Consent form after you sign it**