**Adult Orthodontic Health History Form**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: F M Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DL #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip

Cell Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yrs at present work:\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance: Yes\_\_\_\_\_ No\_\_\_\_\_\_ Orthodontic Coverage: Yes\_\_\_\_\_ No\_\_\_\_\_\_\_

Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

**Check here if responsible party and patient are the same.**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: F M Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DL #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip

Cell Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yrs at present work:\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance: Yes\_\_\_\_\_ No\_\_\_\_\_\_ Orthodontic Coverage: Yes\_\_\_\_\_ No\_\_\_\_\_\_\_

Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #:(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip

**Medical History**

**Y N** Is the patient in good health? If no, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y N** Does the patient have any history of major illness?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y N** Is the patient allergic to any medication/food/other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y N** Is the patient currently taking any medications?( eg bis-phosphonates)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y N** Is the patient currently under the care of a physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Y N** Has the patient had any injuries to the face, mouth, teeth or chin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has the child been diagnosed with or treated for any of the following?**

**Y N** Abnormal Bleeding **Y N** Heart Murmur **Y N** AIDS/HIV+ **Y N** Cleft Palate/Lip **Y N** Any Hospital Stays/ Surgery **Y N** Diabetes **Y N** Hearing/Speech **Y N** Pregnant

Please discuss the above and any other medical problems the child has / had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

What are the main concerns you would like orthodontics to accomplish?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Has an orthodontist been consulted previously?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, name of orthodontist and consult date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Does the patient have any popping, clicking or jaw/joint pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Does the patient have jaw headaches, locked jaws, tiredness of the jaws, limited jaw opening?\_\_\_\_\_\_\_\_\_

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits tot the office. I am responsible for all costs not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPPA CONSENT FORM**

The Health Insurance Portability and Accountability Act of 1996 provides safeguards to protect your privacy. HIPPA provides certain rights and protection to you as a patient. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. It is the policy of the office to remind patients of their appointment. This may be done by telephoning patients or by any other means convenient for the practice. The patient understands and agrees to inspection of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the patient and the practice.

**OFFICE, INSURANCE POLICIES**

**Missed/ Tardiness Appointments**

Appointments are scheduled based on something called “Doctor Time” this basically means that it has been determined, based on the type of appointment, how much time is required by the orthodontist and how much time is required by the orthodontic assistant to take care of patient’s needs. We are often asked if we can squeeze someone in, but this does not work because an unscheduled / tardy patient that is squeezed into the schedule will cause a traffic jam which would result in someone else waiting 15-30 minutes for their scheduled appointment. If you think that you are going to be late, give us a call and we will see what we can do for you. **Three consecutive missed appointments are grounds to discontinue any patient’s treatment at our discreet**

**Insurance**

Please be aware that if your Dental insurance, or any other form of insurances, is dropped for any reason before the treatment is fully paid, you will be responsible for the unpaid balance.

**Broken Brackets**

Broken brackets are a part of orthodontic treatment. It goes with the territory. Sometimes the patient has received trauma to the mouth or maybe they just decided that it would not hurt to cheat a little on the “ No Eats List”. The average patient will break two brackets during their course of treatment. The first 5 broken brackets are on us. After that, there will be **$25.00 charges** for each additional broken bracket. Sometimes brackets will come loose while the patient is just sitting around, but this only happens if the bracket has already been somewhat loosened at an earlier date but did not fully break free from the tooth.

We understand and do not get upset about it. But we do want you to know that broken brackets will result in a delay in treatment. We also want you to know that any appointment that involves the placement of braces **must be done during school hours.** This is a long appointment which cannot be done before or after school because everyone wants to be seen at this time.

**Dental Visits and Cleanings**

Our office will not be checking for cavities during the patient’s visit to our office unless it is obvious without the use of x-rays. Therefore, it is important that the patient see their dentist every 4-6 months for cleanings and check-ups.

Some dental offices ask that the patients present to their office with the orthodontic wires removed so that the dentist or hygienist can do a better job of working around the braces. If your dentist requests that the wires be removed. We will need to make arrangements with you at least 6 weeks in advance for the patient to be seen in our office before and after the dental appointment. The wires can be removed one afternoon and replaced the next afternoon following their dental appointment. We will try to make it as convenient for you as we possibly can.

**By signing below, I state that I have read and understand the office Policies:**

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I consent to allow my child to participate in Global Smiles Orthodontics website and/or any promotional material including, but not limited to, brochures, videos, and newsletters.**

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_