Date: _____

PATIENT INFORMATION

Patient's Name: _____

Address: _____City:_____State:_____ZIP:_____

Birth Date: _____ ☐ Male ☐ Female Age: _____ Cell#_____

List any family member who has had braces before: _____

How did you hear about our office? _____

IF UNDER 18

Parent 1 _____ Relationship_____
Cell _____ Occupation _____

Parent 2 _____ Relationship _____
Cell _____ Occupation _____

School:_____Grade: ____ Hobbies:_____

Siblings and Ages: _____

RESPONSIBLE PARTY -Who will be responsible for financial account(s)?

First Name: _____ Last Name: _____ MI: _____ Marital Status_____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ Email _____

Relation to Patient: _____ Social Security #: _____

Employer: _____ Occupation: _____ No. Years employed: ____

Employer's Address:_____ Phone:_____

DO YOU HAVE ORTHODONTIC INSURANCE?

Insurance Company: _____ Name of Insured: _____

Birth Date: _____ Social Security #: _____ Relation to Patient: _____

Group Number: _____Insurance ID#_____

Insurance Co. Address and Phone Number: _____

Insured Employer_____

DENTAL/MEDICAL HISTORY

Dentist's Name: _____ Phone: _____ Date of last cleaning? _____

Physician's Name: _____ Phone: _____ Date of last visit? _____

Has an orthodontist previously been consulted? NO☐ YES☐ If so, when?_____

What concerns would you like Orthodontics to accomplish? _____

Is the patient currently under a physician's care? NO☐ YES☐

If yes, for what reason? _____

Have the tonsils and adenoids been removed? NO☐ YES☐

Has the patient ever sucked a thumb or finger? NO☐ YES☐

Until what age? ____ Habit still present? NO☐ YES☐

Is the patient currently taking any drugs/medications? NO☐ YES☐

If yes please list: _____

Does the patient have any allergies? NO☐ YES☐

If yes please list: _____

Has there ever been an adverse reaction to latex or nickel? NO☐ YES☐

Does the patient need antibiotics before seeing the dentist? NO☐ YES☐

Have you ever had any of the following diseases or medical problems?

Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Hemophilia
☐	☐	Anemia	☐	☐	Hepatitis
☐	☐	Artificial Bones/ Joints / Valves	☐	☐	High / Low Blood Pressure
☐	☐	Asthma / Arthritis	☐	☐	HIV+ / AIDS
☐	☐	Blood Transfusion	☐	☐	Hospitalized for any reason
☐	☐	Cancer / Chemotherapy	☐	☐	Kidney Problems
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse
☐	☐	Diabetes	☐	☐	Pyschiatric Problems
☐	☐	Difficulty Breathing	☐	☐	Radiation Treatment
☐	☐	Drug / Alcohol Abuse	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Emphysema	☐	☐	Severe / Frequent Headaches
☐	☐	Epilepsy / Seizures / Fainting	☐	☐	Shingles
☐	☐	Fever Blisters / Herpes	☐	☐	Sickle Cell Disease / Traits
☐	☐	Glaucoma	☐	☐	Sinus Problems
☐	☐	Heart Attact / Stroke	☐	☐	Tuberculosis (TB)
☐	☐	Heart Murmur	☐	☐	Ulcers / Colitis
☐	☐	Heart Surgery / Pacemaker	☐	☐	Venereal Disease

Do you have any medical or dental problems not listed? ☐ Yes ☐ No

Please explain:

_____
_____
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_____

The information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status.

I hereby give the office of Suzanne M Dennis DDS MS PC permission to confirm appointments using the phone number(s) provided, including leaving messages.

_____ _____

Signature Patient, Parent or Guardian Date

How do you wish to be notified to confirm appointments?

Phone_____Home☐ Work☐ Cell ☐

E-mail_____

Privacy Acknowledgement for
Suzanne M Dennis DDS MS PC
895 Rio East Court, Suite A
Charlottesville,VA 22936

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my orthodontic treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the office of Suzanne M Dennis DDS MS PC has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

****

Office Use Only

I attempted to obtain the patient's signature of acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: