A B C

**Patient Information**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name

 Last First Middle

Address

 Street City Zip

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a minor, parent’s or guardian’s names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information**

Name

 Last First Middle

Residence

 Street City Zip

Mailing Address

 Street City Zip

Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone

Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # Birth Date Work Phone

**Dental Insurance Information**

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Social Security #

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Local No.

Insurance Co. Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.

Do you have dual coverage? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes:

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Social Security #

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Local No.

Insurance Co. Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.

**Emergency Information**

Name of nearest relative not living with you

Complete address

 Street City Zip

Phone

Signature (Parent’s signature if minor)

Updates (date & initial)

MEDICAL HISTORY

Physician Date of Last Visit

Address Phone

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?

Yes No Have you ever taken any medication for osteoporosis or cancer? What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Are you allergic to any medication?

Yes No Do you have a history of a major illness?

Yes No Have you had any major operations?

Yes No Have you ever been involved in a serious accident?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia

Anemia Dizziness Herpes Prolonged Bleeding

Arthritis Epilepsy High Blood Pressure Radiation/Chemotherapy

Asthma or Hayfever Gastrointestinal Disorders HIV / Aids Rheumatic Fever

Bone Disorders Heart Problems Kidney problems Tuberculosis

Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

# DENTAL HISTORY

Dentist Date of last visit

What concerns you most about your teeth?

Yes No Are you presently in any dental pain?

Yes No Have you ever experienced any unfavorable reaction to dentistry?

Yes No Have you ever lost or chipped any teeth?

Yes No Have there been any injuries to face, mouth or teeth?

Yes No Is any part of your mouth sensitive to temperature or pressure?

Yes No Do your gums bleed when you brush?

Yes No Do you have any type of thumb or tongue habit?

Yes No Are you a mouth breather?

Yes No Have you ever seen an orthodontist? If yes, who and when?

Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?

Yes No Has anyone in your family received orthodontic treatment? How did they feel about the result? What is your attitude toward receiving orthodontic treatment?

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Are you aware of your jaw clicking or popping?

Yes No Are you aware of clenching your teeth during the day?

Yes No Have you ever been told that you grind your teeth?

Yes No Do you have “tension” headaches?

Yes No Have you ever experienced chronic ringing in your ears?

Yes No If the patient is under age 16, height of parents? Mom\_\_\_\_\_\_ Dad\_\_\_\_\_\_

Yes No Are you aware that some appointments will be during school/work hours? Please list some hobbies or interests

 Female Patients only:

Yes No Are you pregnant?

Yes No If a child, Has menstruation started? At what age?

# BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I am aware that periodically new patient appointments are audio recorded for training purposes only. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Crawford to perform a complete orthodontic evaluation.

Signature: Date:

 Doctor’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privacy Notice**

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

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email address, home address, 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 out 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 setting 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; and,
* 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:**

* Amend your protected health information if, for example, it is accurate and complete; or,
* Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard be other patients and third parties.
* YES NO I agree to allow photos/videos of my child/children/self in group events, to be posted on Crawford Orthodontics social networking sites. (If NO, please be aware when attending our events, that photos & videos will be taken.)

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 or direct your questions to this person at our office address. Thank you.

**PATIENT ACKNOWLEDGMENT**

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

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Patient Date

**Please circle any and all sources below which helped you find us. If more than one, please place an \* by the source which you feel was the most influential.**

 ** **

 **Your Dentist Direct Mailer/Postcard**

 ** **

 **Sponsored School Newspaper**

 ** **

 **Friends/Family Billboard**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ** **

**Sponsored Sports Team Stratosphere/Beale AFB**

 ** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**