VROMAN
ORTHODONTICS, P.C.
We'll make you smile.

Member American Association of Orthodontists

Patient Information - Adult

Patient Name _____ Sex: Male Female
First Last M.I.

Birthdate: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Home Address: _____
Apt. No.

City _____ State _____ ZIP _____

Marital Status: _____Spouse/Partner Name: _____

Employer: _____ Work Phone: _____

Have we treated another member of your family? YES NO If YES, Name(s) _____

_____

How did you hear about our office/ whom may we thank for recommending our office? _____

_____

Insurance Information

Insured's Employer:_____ Occupation _____

Insurance Company Name: _____ Ins. Company Phone: _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ Insured's Social Security #: _____

Insured's ID number: _____ Insured's Group Number: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability and 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 for the following:

- Conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers and confirm coverage.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Confirm appointment using voicemail, email, text messaging, postcards, or letters
- Disclose health information to a family member, friend, or caregiver to the extent necessary to help you with your healthcare.

I acknowledge that I have read and/or received the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time to obtain a current copy of the Notice of Privacy 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 information. I also understand that you're not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Please Print

Name of Parent/ Guardian (if under 18): _____

Please Print

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____)_____

Your current physical health is:

☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?

☐ Yes ☐ No

Please explain:_____

Are you taking any prescription/over the counter drugs?

☐ Yes ☐ No

Please list each one: _____

_____

Do you have any sensitivities/allergies? ☐ Yes ☐ No

Please list each one: _____

_____

For women:

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

For growth assessment, has menstruation/period begun?

☐ Yes ☐ No ☐ N/A

Have you ever had any of the following diseases or medical problems? (please circle)

Allergies	Heart Disease/Stroke
Angina/Chest Pains	Heart Murmur/ Defect
Artificial Bones/Joints	Heart Surgery/ Pacemaker
Arthritis	HIV/ AIDS
Asthma	Hepatitis/ Liver Disease
Bleeding Disorder	Kidney Disease
Cancer/Chemotherapy	Mitral Valve Prolapse
Diabetes	Psychiatric Illness
Drug/Alcohol Abuse	Rheumatic/ Scarlet Fever
Ear Infections	Sinus Problems
Emphysema/ COPD	Tuberculosis
Epilepsy/ Seizures	Ulcers/ Colitis
Headaches – Severe/Frequent	Venereal Disease

Has your physician/dentist recommended that you take antibiotics before dental treatment? ☐ Yes ☐ No

DENTAL HISTORY

Why are you seeking orthodontic treatment?

_____

Do you like your smile? ☐ Yes ☐ No

Have you ever seen an orthodontist or received orthodontic treatment before? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/ TMD)? ☐ Yes ☐ No

Your current dental health is:

☐ Good ☐ Fair ☐ Poor

General Dentist: _____

Last visit date: _____

Treatment rendered: _____

Have you ever been treated for periodontal disease?

☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems? ☐ Yes ☐ No

Do you generally breathe through your mouth?

Awake? ☐ Yes ☐ No Asleep? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth?

☐ Yes ☐ No

Do you use any tobacco products? ☐ Yes ☐ No

I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature **Date**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA. the ADA. and the ISDS.

For Office Use Only:

I verbally reviewed the medical/ dental information above with the patient named herein.

Initials: _____ Date: _____