Please fill out to the best of your ability. Fill out the first page that pertains to your age range and complete the medical history, dental history, and HIPPA forms as well.
This information is all confidential.

PATIENT UNDER 18 YEARS INFORMATION FORM; FILL OUT THE FOLLOWING

Patient's Last Name: ____________________________ First Name: ________________________ MI: __________

Birth Date: _________________ Age: ______ Sex: Male ___ Female ___ S.S.N ____________________

Home Phone No.: __________________________ Cell Phone No. _____________________________

Patient's Address: ____

City: ________________________________ State: _______________ Zip/Postal Code: ___________

Attends School At: _____________________ Grade: _______ Musical Instruments Played ________________

Sports And/Or Hobbies: ____

# of brothers and sisters: ___________________________ Ages: ____________________

Other family members or friends treated here: ____

Patient's Height _____________ft._______in. Birth Father's Height ____________ Birth Mother's Height _________

Custodial Parent(s) or Guardian(s): Last Name: ___________________ First Name: _________________ MI: _____

Address (if different than patient's): ____

City: __________________ State/Province: ____ Zip/Postal Code: ________ E-mail address: ____________________

Home Phone No: ______________________ Cell phone _________________ Work Phone No:_________________

Name Of Patient's Dentist: ___________________________Phone No.: ___________________Date Last Seen: _____

Reason___________________________________ Name Of Patient's Physician (s):____________________________

Phone No(s).: ___________________Date Last Seen: _____________________ Reason: _____________________

Who is Financially Responsible For This Account? Last Name:_________________First Name: ___________MI____

Address (if different from patient's): ____

City: _______________________ State: __________ Zip: ______________ Years at this address: _______________

If less than five years, previous address: ____

City: ______________________________ State: ___________________ Zip: _________________

Phone No. (if different than patient's): ___________________________ S.S.N ________________________

Employer: ______________________________________ How many years? ________________________

Insurance Coverage For Orthodontic Treatment? Yes___ No ___

Primary Policy Holder's Name: Last Name: ______________________ First Name: ____________ MI: __________

S.S.N ____________________ Birth Date: ____________

Employed By: ____________________ Dental Insurance Company: __________________ Group No. __________

Who suggested that your child might need orthodontic treatment? ____

Why did you select our office? ____

CONFIDENTIAL Date: ___________

ADULT PATIENT (OVER 18 YEARS) INFORMATION FORM; FILL OUT THE FOLLOWING

Patient's Last Name: ______________________ First Name:_____________________ MI: ________

Birth Date: __________ Age: _____ Sex: ☐Male ☐Female S.S.N________________

Home Phone: __________________ Cell phone: _________________ Work Phone:________________

Patient's Address: _______________________________City:_____________State/Province:____Zip: ______

Email address: _______________________________________Years at above address: ______

If less than 5 years at current address, previous address:____

____Years at previous address: _______

Patient is: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation: ___________________________ Employer: ____________________________________

Years with Employer: ____

Name of Spouse/Closest Relative: ________________________ Phone No.: (if different)______________

Address (if different): ____

City: _____________________________State/Province: ___________Zip/Postal Code: ____________

Name of Patient's Dentist: ____________________________ Phone No.: ________________________

Date Last Seen: ____________ Reason:____

Name Of Patient's Physician(s): __________________________ Phone No(s).: (____) ______-______

Date Last Seen: ____________ Reason: ____

Who suggested that you might need orthodontic treatment? _______________________________________

Why did you select our office? ____

Who Is Financially Responsible For This Account? (if different than patient)

Last Name: ___________________________ First Name: _____________________ MI: ________

Address (if different than patient's) ____

City: _____________________ State/Province: ______ Zip/Postal Code: _____

Phone No: (_____) _______-_________

Insurance Coverage For Orthodontic Treatment? Yes ☐ No☐

Policy Holder's Name: ________________________ S.S.N. ________________Birth Date: ___________

Employed By: ____________________ Dental Insurance Company: ______________ Group No:______

CLARKSBURG ORTHODONTICS
Viney P. Saini, DDS, MS, LLC

For the following questions mark yes or no. The answers are for office records only and will be considered confidential. A thorough and complete is vital to history is vital for a proper orthodontic evaluation. Please answer all that apply.

PATIENT PROFILE

☐**yes** ☐**no** Does patient follow directions well?
☐**yes** ☐**no** Does patient brush his/her teeth consistently?
☐**yes** ☐**no** Does patient have learning disabilities or need extra help with instructions?
☐**yes** ☐**no** Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

☐**yes** ☐**no** Birth defects or hereditary problems?
☐**yes** ☐**n** Bone fractures, any major accidents?
☐**yes** ☐**no** Rheumatoid or arthritic conditions?
☐**yes** ☐**no** Endocrine or thyroid problems?
☐**yes** ☐**no** Kidney problems?
☐**yes** ☐**no** Diabetes?
☐**yes** ☐**no** Cancer, tumor, radiation treatment or chemotherapy?
☐**yes** ☐**no** Stomach ulcer or hyperacidity?
☐**yes** ☐**no** Polio, mononucleosis, tuberculosis, pneumonia?
☐**yes** ☐**no** Problems of the immune system?
☐**yes** ☐**no** AIDS or HIV positive?
☐**yes** ☐**no** Hepatitis, jaundice or liver problem?
☐**yes** ☐**no** Fainting spells, seizures, epilepsy or neurological problem?
☐**yes** ☐**no** Mental health disturbance or depression?
☐**yes** ☐**no** Vision, hearing, tasting or speech difficulties?
☐**yes** ☐**no** Loss of weight recently, poor appetite?
☐**yes** ☐**no** History of eating disorder (anorexia, bulimia)?
☐**yes** ☐**no** Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐**yes** ☐**no** High or low blood pressure?
☐**yes** ☐**no** Tired easily?
☐**yes** ☐**no** Chest pain, shortness of breath or swelling ankles?
☐**yes** ☐**no** Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐**yes** ☐**no** Skin disorder?
☐**yes** ☐**no** Frequent headaches, colds or sore throats?
☐**yes** ☐**no** Eye, ear, nose or throat condition?
☐**yes** ☐**no** Hayfever, asthma, sinus trouble or hives?
☐**yes** ☐**no** Tonsil or adenoid conditions?
☐**yes** ☐**no** Osteporosis?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding Disorders _____ **Diabetes**______
Arthritis_____ **Severe Allergies**______
Unusual Dental problems______ **Jaw size imbalance**_____
Any other family medical conditions that we should know about?
If you answered yes to any above please elaborate___________
____

Allergies or reactions to any of the following:

☐**yes** ☐**no** Ibuprofen (Motrin, Advil)
☐**yes** ☐**no** Penicillin or other antibiotics
☐**yes** ☐**no** Metals (jewelry, clothing snaps)
☐**yes** ☐**no** Latex (gloves, balloons)
☐**yes** ☐**no** Vinyl
☐**yes** ☐**no** Acrylic
☐**yes** ☐**no** Other substances (specify) ____________________
☐**yes** ☐**no** Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _________________ Taken for ________________
Medication _________________ Taken for _________________

☐**yes** ☐**no** Does the patient currently have or ever had a substance abuse problem?
☐**yes** ☐**no** Does the patient chew or smoke tobacco?
☐**yes** ☐**no** Operations? Describe:
☐**yes** ☐**no** Hospitalized? For:
☐**yes** ☐**no** Other physical problems or symptoms?
Describe:
☐**yes** ☐**no** Being treated by another health care professional?
For:
Date of most recent physical exam?___________________
Are there any other medical conditions that we should be aware of?

FEMALES ONLY

☐**yes** ☐**no** Has the patient started her monthly periods?
If so, approximately when? ________________________
☐**yes** ☐**no** Is the patient pregnant?_________________

CLARKSBURG ORTHODONTICS
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DENTAL HISTORY

Now or in the past, has the patient had:

☐**yes** ☐**no** Started teething very early or late?

☐**yes** ☐**no** Primary (baby) teeth removed that were not loose?

☐**yes** ☐**no** Permanent or "extra" (supernumerary) teeth removed?

☐**yes** ☐**no** Supernumerary (extra) or congenitally missing teeth?

☐**yes** ☐**no** Chipped or otherwise injured primary (baby) or permanent teeth?

☐**yes** ☐**no** Teeth sensitive to hot or cold; teeth throb or ache?

☐**yes** ☐**no** Jaw fractures, cysts or mouth infections?

☐**yes** ☐**no** "Dead teeth" or root canals treated?

☐**yes** ☐**no** Bleeding gums, bad taste or mouth odor?

☐**yes** ☐**no** Periodontal "gum problems"?

☐**yes** ☐**no** Food impaction between teeth?

☐**yes** ☐**no** Thumb, finger, or sucking habit? Until what age ___?

☐**yes** ☐**no** Abnormal swallowing habit (tongue thrusting)?

☐**yes** ☐**no** History of speech problems?

☐**yes** ☐**no** Mouth breathing habit, snoring or difficulty in breathing?

☐**yes** ☐**no** Tooth grinding, jaw clenching clicking or locking?

☐**yes** ☐**no** Any pain in jaw or ringing in the ears?

☐**yes** ☐**no** Any pain or soreness in the muscles of the face or around the ears ?

☐**yes** ☐**no** Difficulty encountered in chewing or jaw opening?

☐**yes** ☐**no** Aware of loose, broken or missing restorations (fillings)?

☐**yes** ☐**no** Any teeth irritating cheek, lip, tongue or palate?

☐**yes** ☐**no** Concerned about spaced, crooked or protruding teeth?

☐**yes** ☐**no** Aware or concerned about under or over developed jaw?

☐**yes** ☐**no** "Gum Boils", frequent canker sores or cold sores?

☐**yes** ☐**no** Taking any forms of fluoride?

☐**yes** ☐**no** Any relative with similar tooth or jaw relationships?

☐**yes** ☐**no** Had periodontal (gum) treatment?

☐**yes** ☐**no** Has the patient ever been treated for “TMD” o”TMJ” problems?

☐**yes** ☐**no** Any wisdom tooth problems?

☐**yes** ☐**no** Would patient object to wearing braces should they be indicated?

☐**yes** ☐**no** Any serious trouble associated with any previous dental treatment?

☐**yes** ☐**no** Ever had a prior orthodontic examination or treatment?

☐**yes** ☐**no** Been under another dentist's care?
Specialist ______________________
Other ______________________

How often does the patient brush? ___ Floss?

What is your primary concern? Why are you here?_____________

____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: ____

Date Signed: ________________
(Parent or Guardian)

Signed: ____

Date Signed: ________________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES 6 mo.

Comments:

Signed: ____
Date Signed: ________________
(Parent or Guardian)
Signed: ____
Date Signed ________________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES 12 mo

Comments:

Signed: ____
Date Signed: ________________
(Parent or Guardian)
Signed: ____
Date Signed ________________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES 18 mo

Comments:

Signed: ____
Date Signed: ________________
(Parent or Guardian)
Signed: ____
Date Signed ________________
(Dental Staff Member)

Patient Consent to receive Mail and or/ Telephone Messages

____

Please Print **(Last Name)** **(First Name)** **(M.I.)**

Do we have your permission to:

Send a recall appointment reminder to your home? Y _____ N _____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y _____ N _____

I give permission to share appointment, billing or dental information with the person named below: Y _____ N _____

Name: ____

____________________________________ ______________________

Signature of Patient / Parent or Legal Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have received (Also available on www.ClarksburgOrtho.com) a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

______________________________ ______________________

Signature of Patient / Parent or Legal Guardian Date

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED 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 addresses, home addresses, 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 our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers 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 files 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:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- 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 by other patients and third parties.

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.