

**ADULT PATIENT INFORMATION**

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City Zip

Mailing Address \_\_\_\_\_  
Street City Zip

How long at this address? \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Previous Address (If less than 3 years) \_\_\_\_\_

Cell Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Email Address \_\_\_\_\_ Marital Status: Single\_\_ Married\_\_ Widowed\_\_ Separated\_\_ Divorced\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

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

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

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

**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 \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Signature \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

**MEDICAL HISTORY**

Patient's Name \_\_\_\_\_ Patient's date of birth \_\_\_\_\_  
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 Are you allergic to any medication? \_\_\_\_\_
- Yes No Do you have a history of a major illness? \_\_\_\_\_
- Yes No Have you had any operations? \_\_\_\_\_
- Yes No Have you ever been involved in a serious accident? \_\_\_\_\_
- Yes No Have you ever smoked or chewed tobacco? \_\_\_\_\_
- Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_
- Female Patients only:
- Yes No Are you pregnant? \_\_\_\_\_
- Yes No Has menstruation started? \_\_\_\_\_

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? \_\_\_\_\_

**DENTAL HISTORY**

General 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 your wisdom teeth been removed? \_\_\_\_\_
- 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? Where? \_\_\_\_\_
- Yes No Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_
- 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 What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_
- Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_
- How did they feel about the result? \_\_\_\_\_
- 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 Are you aware that some appointments will be during work hours? \_\_\_\_\_

**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 understand that my diagnostic records and my name may be used for educational and promotional purposes. 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. Gabriela Aranda "Dr. Gaby" to perform a complete orthodontic evaluation and authorize the doctor and dental staff to perform the necessary dental services I may need during treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Gresham Orthodontics  
2150 NE Division Street, Suite 203  
Gresham, OR 97030

### Notice of Privacy Acts Consent Form

I understand that I have certain rights given to me under the Health Insurance Portability and Accountability Act (HIPPA) regarding my protected health information. I understand that by signing this consent I authorize you to use and disclose my protected health information for the following:

- Treatment including that given by all health care providers involved in my care.
- Obtaining payment from third party payers including insurance companies and other paying parties.
- The day-to-day health care practices of the orthodontic practice.

I have also been informed that I may request a copy of 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 that I may contact this organization at any time at the address above to obtain a current copy or 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 health care 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.

I understand that I may ask that this consent be revoked but I must do so in writing. However, any use or disclosure that occurred prior to the date is not affected.

**Patient Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

<b>Date:</b>	<b>Initials:</b>	<b>Reason:</b>
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