MeadowsFamilyDentistry

pediatric • orthodontic • adult care

Smiles for Life

Adult Orthodontic Registration

Tell us about yourself: **Date:** _____

Patient's Full Name: _____ Sex: M F D.O.B: _____/_____/_____

Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Your Employer: _____ How Long: _____ Patient is: Single Married Divorced Widowed

Current Dentist: _____ Date of Last Cleaning_____ Is all dental work complete Y / N

Insurance Information

Do you Have Dental Insurance? Yes No Insurance Co. Name: _____ Phone: _____

Insurance Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Patient's Relationship to Insured: Self Spouse Child Partner Other

Member ID# (may be SSN): _____ Policy/Group #: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the end result of your Orthodontic treatment. Thank you in advance for answering the following questions. All information is kept confidential.

General Health: Excellent Good Fair Poor **Are you Taking Medication**? Yes No

Please List Medications: _____

_____

Preferred Pharmacy: _____ Location: _____ Phone #: (___)_____

Women: Are you… Pregnant Trying to get pregnant Nursing

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal **Latex** Sulfa Drugs Local Anesthetics

Do you have allergies to any other medications? Yes No If Yes: _____

Do you use controlled Substances? Yes No If Yes: _____

Do you ever have any clicking, popping or pain associated with jaw opening/closing? Yes No

Do your jaws ever feel tired or sore? Yes No Do you grind or clench your teeth? Yes No

How did you hear about our office? Who may we thank for referring you: _____

Are you currently under the care of a physician? Yes No If Yes: _____

Have you ever been hospitalized or had a major operation? Yes No If Yes: _____

Have you ever had a severe blow to the teeth or jaws? Yes No If Yes: _____

Do you have sore or bleeding gums? Yes No If Yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If Yes: _____

Is there any difficulty chewing or swallowing food? Yes No If Yes: _____

Does any member of your family have similar appearance of jaws? Yes No If Yes: _____

Have you or any member of the family had orthodontic treatment? Yes No If Yes, Who_____

What is your primary concern in seeking orthodontic treatment : Appearance? Better Digestion? Better Speech? On Advice of Dentist?

What are your feelings about possibly having orthodontic treatment? _____

Do you have or ever had any of the following?

___ AIDS/HIV Positive
___ Alzheimer 's disease
___ Anaphylaxis
___ Anemia
___ Angina
___ Arthritis/Gout
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Blood Disease
___Blood Transfusion
___Breathing Problems
___Bruise Easily
___ Cancer
___ Chemotherapy
___ Chest Pains
___ Cold Sore/Fever Blister
___ Congenital Heart Disorder
___ Convulsions
___ Yellow Jaundice
___ Cortisone Medicine
___ Diabetes
___Drug Addiction
___Emphysema
___Epilepsy or Seizures
___ Excessive Bleeding
___ Excessive Thirst
___ Fainting/Dizziness
___ Frequent Cough
___ Frequent Diarrhea
___ Frequent Headaches
___ Herpes/Genital Herpes
___ Glaucoma
___ Hay Fever
___ Heart Attack/Failure
__ Heart Murmur
___ Heart Pacemaker
___ Heart Trouble/Disease
___ Hemophilia
___ Hepatitis A B or C
___ High Blood Pressure
___ High Cholesterol
___ Hives or Rash
___ Hypoglycemia
___ Irregular Heartbeat
___ Kidney Problems
___ Leukemia
__ Liver Disease
___ Low blood Pressure
___ Lung Disease
___ Mitral Valve Prolapse
___ Osteoporosis
___Pain in Jaw Joints
___ Parathyroid Disease
___ Psychiatric Care
___ Radiation Treatment
___ Recent Weight Loss
___ Renal Dialysis
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Shingles
___ Sickle Cell Disease
___ Sinus Trouble
___ Spina Bifida
___ Stomach Disease
___ Stroke
___ Swelling of Limbs
___ Thyroid Disease
___ Tonsalitis
___ Tuberculosis
___ Tumors or Growths
___ Ulcers
___ Venereal Disease

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's (Patient's Representative) signature: _____ Date: _____

We take great pride in providing the BEST care available!!

4/2021

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HIPAA Disclosure and Release of Information

I, _____, hereby authorize Meadows Family Dentistry, LLC (hereafter collectively referred to as the "Practice") to use and disclose the entire medical record concerning _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have received and reviewed a copy of the NOPP, been given an opportunity to ask questions about it, understand it and do here by agree to its terms. A copy of this signed, dated Consent shall be effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

_____ _____ _____

Patient Name | Signature of patient or parent/guardian | Date

Consent for Communication and/or Disclosure

I request the following alternative or limitations relating to communication directed to me by my healthcare provider or employee of Meadows Family Dentistry, LLC. I understand that this HIPAA consent applies to ALL providers of Meadows Family Dentistry. It is my responsibility to notify Meadows Family Dentistry of any changes.

Do we have permission to:

Send appointment reminders via (please check the following): TEXT ☐ EMAIL ☐ BOTH ☐

Leave the following information on your home/cell voicemail?

Appointment Information ___Yes___No

Billing Information ___Yes ___No

Medical Information ___Yes ___No

I give my permission to share the following information with the person(s) listed below:

Name: _____ Relationship: _____

Appointment: ___Yes ___No Billing: ___Yes ___No Medical: ___Yes ___No

Name: _____ Relationship: _____

Appointment: ___Yes ___No Billing: ___Yes ___No Medical :___Yes ___No

_____ _____ _____

Patient Name | Signature of patient or parent/guardian | Date