WELCOME TO FOX & ABRAHAM ORTHODONTICS!

Kindly provide the following information to help us serve you best:

Thank you!

Date: ____ /____ /____

PATIENT INFORMATION - Adult

NAME: _____ _____

First *Initial* *Last* Nickname (if preferred)

Date of Birth: ____ /____ /____ Age: _____ yrs Male ___ Female ___

Address: _____ City: _____ Zip: _____

Cell Phone: (____) ____ _____ **Email**: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) ____ _____

How did you hear about our office? _____

Have we treated another family member? Yes / No If yes, Name _____

DENTAL INSURANCE: Please bring your Dental Insurance Card to the initial appointment.

PRIMARY INSURANCE

Insurance Company: _____ Insurance Phone #: (____) ____ _____

Insurance Company Address: _____

Subscriber's Name: _____

Subscriber's Date of Birth: ____ /____ /____ Relationship to Patient: _____

Group/Plan # _____ ID # _____

Subscriber's Employer: _____

SECONDARY INSURANCE

Insurance Company: _____ Insurance Phone #: (____) ____ _____

Insurance Company Address: _____

Subscriber's Name: _____

Subscriber's Date of Birth: ____ /____ /____ Relationship to Patient: _____

Group/Plan # _____ ID # _____

Subscriber's Employer: _____

If the patient is not the Policy Holder, is the subscriber(s) aware that the patient is seeking orthodontic treatment? Yes No

MEDICAL HISTORY:

Physician: _____ Last visit: ____ /____ /____ Phone: (___) ____ _____

Are you in good health?	Yes	No
Has there been a change in your health status in the last year?	Yes	No
Have you had any serious illness or surgery in the past? If yes, why_____	Yes	No
Have you had treatment for any condition of your head or neck?	Yes	No
Have you received medical treatment from an allergist or an ENT specialist?	Yes	No
Have you had nasal surgery, or had tonsils or adenoids removed?	Yes	No
Do you have or have had any of the following?		
Birth Defects or Hereditary Problems	Yes	No
Frequent Headaches or Migraines	Yes	No
Oral Herpes or Cold Sores	Yes	No
Rheumatic Fever or Rheumatic Heart Disease	Yes	No
Cardiovascular Disease or Cardiac Pacemaker	Yes	No
Sinus troubles	Yes	No
Respiratory disorders like Asthma, Hay fever or Lung disease	Yes	No
Neurological disorders like epilepsy, seizures, fainting	Yes	No
Mental Health concerns	Yes	No
Diabetes or Family history of Diabetes	Yes	No
Liver disease like hepatitis or jaundice	Yes	No
Arthritis or Joint problems	Yes	No
Gastro-intestinal disorders like Celiac disease, Crohn's disease, polyps	Yes	No
Kidney disorders	Yes	No
Blood disorders like anemia, hemophilia	Yes	No
Immune deficiency disorders	Yes	No
Osteoporosis or related bone disorders	Yes	No
Hormonal Concerns or imbalances	Yes	No
Sleep Apnea or related conditions	Yes	No
Are you on any medications or have had medications intravenously? If **yes**, please name them: _____	Yes	No
Are you allergic to or reacted badly to any medications or a known allergen? If **yes**, please name them: _____	Yes	No

Do you have any disease, condition or problem that is not listed above that you think we should know about? If so, please explain:

_____

DENTAL HISTORY:

General Dentist: _____ City: _____ Phone: (___) ____ _____

Frequency of visits: _____ **History of Patient's Dental Experience:** Positive / Negative

Have you had a previous orthodontic consultation?	Yes	No
Have you had previous orthodontic treatment? If yes, when _____	Yes	No
Are you in **good dental health**?	Yes	No
Do you require antibiotics before dental treatment? If yes, why _____	Yes	No
Have there been any problems associated with any previous dental treatment?	Yes	No
Have you ever been hit on the face and/or on the mouth If yes, when and how _____	Yes	No
Have any teeth or lips been injured? If yes, describe the injury & treatment _____	Yes	No
Have you had your wisdom teeth removed?	Yes	No
Have you been treated for periodontal disease (gum disease) ?	Yes	No
Do you regularly use tobacco or cannabis products?	Yes	No
Have you had any TMJ symptoms like pain, clicking, limitation to opening?	Yes	No
Have you been treated for TMJ disorders or problems?	Yes	No
Have you ever received, or been asked to receive speech therapy?	Yes	No
Do you presently have or a history of any of the following **habits**?		
Lip biting or cheek biting	Yes	No
Thumb or finger sucking	Yes	No
Nail biting or Foreign object biting	Yes	No
Mouth breathing	Yes	No
Tongue thrusting	Yes	No
Clenching or grinding	Yes	No
Any other habits? If yes, explain _____	Yes	No
Any **family dental history** like missing/extra/impacted teeth /jaw discrepancies? If yes, explain _____	Yes	No

Reasons for seeking Orthodontic Treatment: _____

Is there any other information that you believe would be helpful to us? If so, please explain:

_____

I acknowledge that the information I have provided is accurate to the best of my knowledge and will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes to the above and I hereby consent to examination by the doctor.

Signature _____ Print Name _____ Date ____ /____ /____

NOTICE OF PRIVACY PRACTICES & AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Fox & Abraham Orthodontics PC., provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

By signing below, the patient/parent/guardian understands and consents to the following:

- The protected health information may be disclosed or used for treatment, health care operations or payment/insurance claims and may include, but not limited to the patient's treating physician or dentist, specialists that the patient sees or may be referred to, or any other individuals the doctor deems necessary to ensure appropriate care & treatment of the patient.
- Fox & Abraham Orthodontics PC has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice.
- Fox & Abraham Orthodontics PC reserves the right to modify/change its Notice of Privacy Practices at any time.
- The patient has the right to restrict the use of their health information, but the practice does not have to agree to the restrictions.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.
- The patient may revoke this Consent by notifying Fox & Abraham Orthodontics in writing at any time in the future. However, such a revocation shall not affect any disclosures made by Fox & Abraham Orthodontics in reliance on your prior Consent.

Additional Disclosure Authority:

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of the protected health information to the persons indicated below:

ANY IMMEDIATE FAMILY MEMBER	Yes	No
PARENT ONLY	Yes	No
OTHER (Please Specify) _____	Yes	No

I also understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

_____ ___ /___ /___

Signed (Patient OR Insured Parent/Guardian) Date

Print Name: _____

Circle Relationship: SELF/PARENT/LEGAL GUARDIAN