JEFF THOMPSON ORTHODONTICS

CONFIDENTIAL MEDICAL DENTAL HISTORY FOR ADULT PATIENTS

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Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ Age: _____ Sex: Male ❑ Female ❑ I Prefer to be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: _____

Cell Phone No: _____

Patient's Address: _____ City: _____

State: _____ Zip/Postal Code: _____ email address: _____

Years at above address: ____ If less than 5 years, previous address: _____

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

Occupation: _____ Employer: _____ Years with employer: _____

Business Phone No _____

Name of Spouse/Closest Relative: _____ Relationship to you: _____

Address (if different than yours): _____

Who referred you to our office? _____

Dentist's name: _____ Phone: _____

Address: _____

Physician's name: _____ Phone: _____

Address: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____ State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____ State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

MEDICAL HISTORY : Now or in the past, have you had:

- ❑ Yes ❑ No Birth defects or hereditary problems?
- ❑ Yes ❑ No 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 or pneumonia?
- ❑ Yes ❑ No Problems of the immune system?
- ❑ Yes ❑ No AIDS or HIV positive?
- ❑ Yes ❑ No Hepatitis, jaundice or liver problems?
- ❑ Yes ❑ No Fainting spells, seizures, epilepsy or neurological problem?
- ❑ Yes ❑ No Mental health disturbance or behavioral problem?
- ❑ 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 Bleeding disorder, bruising tendency, excessive bleeding or anemia?
- ❑ Yes ❑ No High or low blood pressure?
- ❑ Yes ❑ No Tires 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 Does the patient eat a well-balanced diet?
- ❑ 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 Osteoporosis?

Allergies or reactions to any of the following:

- ❑ Yes ❑ No Local anesthetics (Novocaine or Lidocaine)
- ❑ Yes ❑ No Aspirin
- ❑ Yes ❑ No Ibuprofen (Motrin, Advil)
- ❑ Yes ❑ No Penicillin or other antibiotics
- ❑ Yes ❑ No Sulfa drugs
- ❑ Yes ❑ No Codeine or other narcotics
- ❑ Yes ❑ No Metals (jewelry, clothing snaps)
- ❑ Yes ❑ No Latex (gloves, balloons)
- ❑ Yes ❑ No Vinyl
- ❑ Yes ❑ No Acrylic
- ❑ Yes ❑ No Animals
- ❑ Yes ❑ No Foods (specify) _____
- ❑ Yes ❑ No Other substances (specify) _____

❑ Yes ❑ No Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

- ❑ Yes ❑ No Do you currently have or ever had a substance abuse problem?
- ❑ Yes ❑ No Do you chew or smoke tobacco?
- ❑ Yes ❑ No Operations? (specify) _____
- ❑ 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: _____

- ❑ Yes ❑ No Are there any other medical conditions that we should be aware of?

_____

WOMEN ONLY

- ❑ Yes ❑ No Are you pregnant?
- ❑ Yes ❑ No Are you anticipating becoming pregnant?

I have read and understand the above questions. I will not hold my orthodontist or any staff member 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: _____
(Patient)

Signed: _____ Date signed: _____
(Dental Staff Member)

DENTAL HISTORY: Now or in the past, have you had:

- ❑ Yes ❑ No Permanent or "extra" (supernumerary) teeth removed?
- ❑ Yes ❑ No Supernumerary (extra) or congenitally missing teeth?
- ❑ Yes ❑ No Chipped or otherwise injured teeth?
- ❑ Yes ❑ No Teeth sensitive to hot or cold; 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 thrust)?
- ❑ 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 in chewing or jaw opening?
- ❑ Yes ❑ No Any loose, broken, or missing 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," 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 Would you object to wearing orthodontic appliances (braces) should they be indicated?
- ❑ Yes ❑ No Any serious trouble associated with any previous dental treatment?

How often do you brush: _____ floss: _____

❑ Yes ❑ No Have you ever had a prior orthodontic examination or treatment?

Doctor's name: _____ Date of treatment: _____

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 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: _____
(Patient)

Signed: _____ Date signed: _____
(Dental Staff Member)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received/read a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communications barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (Please Specify)

_____

_____

_____

Jeff Thompson Orthodontics

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. Protection of patient privacy is important to us. This notice summarizes the privacy practices that will be followed by Jeff Thompson Orthodontics, We are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect february 1st, 2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician or other health care provider providing treatment to you.
Payment We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person involved in your treatment to the extent necessary to help with your healthcare.

Persons Involved In Care: We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders : We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.40 for each page and $14.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You may request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We may agree to reasonable requests.

Amendment: You may request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice : If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact : Jeffrey J. Thompson. DDS,MS

Telephone : 913.681.8300 Fax : 913.681.8303

Web:: JeffThompsonOrtho.com

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