Patient Information

Date _____

Patient's Full Name _____
First Middle Last

Sex _____ Age _____ Birth Date _____ Marital Status _____

Home Address _____ City _____ Zip _____

Home# _____ Cell# _____ Social Security# _____

Employed By _____ Position Held _____

Business Address _____ Telephone _____

Name of Spouse _____ Social Security# _____ Spouse's Cell# _____

Spouse Employed By _____ Position Held _____ Work# _____

Spouse's Business Address _____

Family Dentist _____ Date of Last Cleaning _____

Whom may we thank for referring you to our office? _____ Physician _____

In case of emergency, name of nearest relative not living with you _____

Complete address _____ Telephone _____

Any Previous Orthodontic treatment? (When?) _____	Yes ❑	No ❑
Any Previous Gum treatment? _____	Yes ❑	No ❑
Do Your Gums Bleed on Brushing? _____	Yes ❑	No ❑
Do You Experience frequent headaches? _____	Yes ❑	No ❑
Do You Experience chronic neck or shoulder pain? _____	Yes ❑	No ❑
Do You Experience aches or pain in the side of your face? _____	Yes ❑	No ❑
Are you Aware of Clenching or Grinding Your Teeth During the Day or Night? _____	Yes ❑	No ❑
Do You Have a History of Any injuries to the Face, Mouth or Teeth? _____	Yes ❑	No ❑
Are You in Good Health? _____	Yes ❑	No ❑
Do You Have a History of any Major Condition or Illness? _____	Yes ❑	No ❑

If yes, please list: _____

Please List Any Allergies or Drug Sensitivities _____

Responsible Party Information

Name _____
First Middle Last Marital Status

Address _____ City _____ State _____ Zip _____

How long at this address _____ Own or Rent _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs. _____ City _____ State _____ Zip _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ❑ No ❑ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

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

Signature _____

Updates (date & initial) _____ _____ _____ _____ _____

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medications, drugs or pills now? ..... Yes No
   If yes, please list

Medication	Dose	Reason
1.		
2.		
3.		
4.		

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores / Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special / Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous / Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric / Psychological Care	Yes	No

7. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
8. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
9. **WOMEN** - Are you: Pregnant? ____ Yes, Months No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

MAHLMANN & BORDERS ORTHODONTICS
The Art of Orthodontics

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. i.e. contact with your dentist, physician, pediatrician or oral surgeon, etc. from our office. Also to include contact with Insurance Companies and Electronic transactions.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Patient's Name: _____

Email: _____

Patient, Parent or Guardian Signature

Signature: _____ Date: _____

If this Consent is signed by a legal guardian or representative on behalf of the patient, complete the following:

Legal Guardian or Representative's Name: _____

Relationship to Patient: _____

Please sign this form and return with Medical information and Patient History Form at exam appointment.