westrock ORTHODONTICS

Patient Information

Date: _____

Patient Name: _____ I prefer to be called: _____
Birthdate: _____ Patient SSN : _____ Driver's License#: _____
Address: _____ City: _____ St: ____ Zip: _____
Email Address: _____Phone: Work_____ Cell _____
The best way to contact me is on my: ▢ Work Phone ▢ Cell Phone ▢ Text Message ▢ Email
Gender: ▢ Male ▢ Female Marital Status: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced
If you are a student, please list your school: _____
How did you hear about our office? _____
If you have a dentist, please list your dental provider: _____

Employer

Patient's Employer:_____
Employer Address:_____City:_____St:_____Zip:_____

Spouse

Spouse's Name:_____Employer:_____
Birth Date:_____SSN:_____Driver's License#: _____
Email Address: _____Phone: Work_____ Cell _____

Emergency Contact

Name of Emergency Contact: _____ Relationship to patient: _____
Email Address: _____ Phone: Work _____ Cell _____

Parent or Guardian Information: *If the patient is a child.*

Parent/Guardian 1: _____ Relationship: _____
Address: _____ City: _____ St: ____ Zip: _____
Email Address: _____ Phone: Work _____ Cell _____
The best way to contact me is on my: ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email
Birthdate: _____ SSN : _____ Driver's License #: _____
Check the appropriate box: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced
Parent/Guardian 2:_____ Relationship: _____
Address: _____ City: _____ St: ____ Zip: _____
Email Address: _____ Phone: Work _____ Cell _____
The best way to contact me is on my: ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email
Birthdate: _____ SSN : _____ Driver's License #: _____
Check the appropriate box: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced

Person Responsible for Account

Name: _____ Relationship to patient: _____
Billing Address: _____ City: _____ St: ____ Zip: _____
Email Address: _____ Phone: Work _____ Cell _____
The best way to contact me is on my: ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email
Birthdate: _____ SSN : _____ Driver's License #: _____

Insurance Information

Do you have orthodontic coverage? ▢ Yes ▢ No
Name of Insured: _____ Birth date: _____
Relationship to patient: _____ Insured SSN: _____
Name of employer: _____ Work Phone: _____
Work Address: _____ City: _____ St: ____ Zip: _____
Insurance Company: _____ Group No: _____ ID No: _____
Ins. Co. Address: _____ City: _____ St: ____ Zip: _____
Ins. Co. Phone: _____
Do you have any additional insurance? ▢ Yes ▢ No *If yes, please complete the following.*
Name of Insured: _____ Birth date: _____
Relationship to patient: _____ Insured SSN: _____
Name of employer: _____ Work Phone: _____
Work Address: _____ City: _____ St: ____ Zip: _____
Insurance Company: _____ Group No: _____ ID No: _____
Ins. Co. Address: _____ City: _____ St: ____ Zip: _____
Ins. Co. Phone: _____

Dental Health History

What are the main concerns that you would like orthodontics to accomplish?

_____

Have you ever had or been evaluated for orthodontic treatment? ▢ Yes ▢ No
Have you ever had a serious or difficult problem associated with any previous dental work? ▢ Yes ▢ No
Do you know or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ▢ Yes ▢ No
Your current dental health is: ▢ Good ▢ Fair ▢ Poor
Do you like your smile? ▢ Yes ▢ No
Do your gums ever bleed? ▢ Yes ▢ No
Have you ever had an injury? ▢ Mouth ▢ Teeth ▢ Chin ▢No
Do you generally breathe through your mouth? ▢ Yes ▢ No
If yes, please select when: ▢ While Awake ▢ While Asleep
Do you have any missing or extra permanent teeth? ▢ Yes ▢ No
Have you ever taken Phen-Fen? (aka: Redux and Pondimin) ▢ Yes ▢ No If yes, when? Date: _____
Do you smoke or use tobacco in any form? ▢ Yes ▢ No

Medical Health History

Do you have a personal physician? ▢ Yes ▢ No Date of last visit?_____
Physician's Name: _____ Practice Phone: _____
Address: _____ City: _____ St: ____ Zip: _____
Are you currently under the care of a physician? ▢ Yes ▢ No If yes, please explain:_____
Your current physical health is: ▢ Good ▢ Fair ▢ Poor

Please list any medications you are currently taking:

_____

_____

For Women:

Are you taking birth control? ▢ Yes ▢ No

Are you pregnant? ▢ Yes ▢ No ▢ Uncertain Week #: _____

Are you nursing? ▢ Yes ▢ No

Have you ever had any of the following diseases or medical problems? Please check the appropriate box.

- ▢ Abnormal Bleeding
- ▢ Anemia
- ▢ Arthritis
- ▢ Artificial Bones/Joints/Valves
- ▢ Asthma
- ▢ Blood Transfusion
- ▢ Cancer or Chemotherapy
- ▢ Congenital Heart Defect
- ▢ Diabetes
- ▢ Drug or Alcohol Abuse
- ▢ Emphysema
- ▢ Epilepsy, Seizures or Fainting
- ▢ Fever Blister / Herpes
- ▢ Glaucoma
- ▢ Hearing or Vision Impaired
- ▢ Heart Attack / Stroke
- ▢ Heart Murmur
- ▢ Heart Surgery / Pacemaker
- ▢ Hemophilia
- ▢ Hepatitis
- ▢ High or Low Blood Pressure
- ▢ HIV+ / AIDS
- ▢ Kidney Problems or Diseases
- ▢ Mitral Valve Prolapse
- ▢ Psychiatric Problem
- ▢ Radiation Therapy
- ▢ Respiratory Problems
- ▢ Rheumatic / Scarlet Fever
- ▢ Shingles
- ▢ Sickle Cell Disease / Traits
- ▢ Sinus Problems
- ▢ Thyroid Problem
- ▢ Tuberculosis (TB)
- ▢ Ulcers / Colitis
- ▢ Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following? Please check the appropriate box.

- ▢ Aspirin
- ▢ Tetracycline
- ▢ Sulfa Drugs
- ▢ Erythromycin
- ▢ Latex
- ▢ Iodine
- ▢ Penicillin
- ▢ Any Metals or Plastics
- ▢ Plastic
- ▢ Codeine
- ▢ Dental Anesthetics
- ▢ Other

Please list any other drugs or materials that you are allergic to:

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature **Date**

General

By signing below, I understand that this office reserves the right to verify the credit status of potential patients and or the legal guardians of patients prior to extending credit for treatment fee and may, at the discretion of the office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

If the patient is a minor, I understand that a legal guardian must be present at the new patient appointment, contract and any consent appointments. Any person bringing the patient to an appointment must be added to the patient's HIPAA form by the legal guardian prior to the appointment.

_____

Signature **Date**

Text and Email Policy

Westrock Orthodontics can email and/or text you appointment reminders and general information about our services. If you would like to receive communications via email or text in the future, please read and sign the consent attached below.

Consent to Email and/or Text Message for Appointment Reminders and Other Communications:
You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but chargers from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

Patient Name _____ Guardian Name (if patient is a minor) _____
Communication Preference: ▢ Text ▢ Email

_____

Signature **Date**

Notice of Privacy Practices and Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your 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 copy of 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.

_____ _____

Patient Name **Relationship to Patient**

_____ _____

Signature **Date**

Please, list below any person who can receive PHI (Protected Health Information) on this patient.

Name	Relationship	Treatment Info.		Ledger	
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No

OFFICE USE ONLY *I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:*

_____ _____ _____

Date **Initials** **Reason**