WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name ________________ (Last) ________________ (First) ______ (Middle) Sex Marital Status

Address ________________ (Street) ________________ (City) ______ (State) ______ (Zip)

Birthdate ________________ (MM-DD-YYYY) E-mail ________________ Social Security# ________________ (999-99-9999)

Home Phone ________________ (999-999-9999) Cell Phone ________________ (999-999-9999) Work Phone ________________ (999-999-9999) ext. ______

Employer ________________ Occupation ________________ No. Years Employed ______

General Dentist ________________ Last Visited ________________

Who may we thank for referring you to our office ________________

Spouse / Additional Contact Information

Name ________________ (Last) ________________ (First) ______ (Middle) Marital Status

Address ________________ (Street) ________________ (City) ______ (State) ______ (Zip)

Birthdate ________________ (MM-DD-YYYY) E-mail ________________ Relationship to Patient ________________

Home Phone ________________ (999-999-9999) Cell Phone ________________ (999-999-9999) Work Phone ________________ (999-999-9999) ext. ______

Employer ________________ Occupation ________________ No. Years Employed ______

Insurance Information

Policy Owner's Name ________________ Policy Owner's Social Security # ________________ (999-99-9999)

Policy Owner's Birthdate ________________ (MM-DD-YYYY) Relationship to Patient ________________

Policy Owner's Employer ________________ Employer's Address ________________

Insurance Company ________________ Group No. (plan, local, or policy) ________________

Insurance Co. Address ________________ Insurance Phone No. ________________

Secondary Insurance

Policy Owner's Name ________________ Policy Owner's Social Security # ________________ (999-99-9999)

Policy Owner's Birthdate ________________ (MM-DD-YYYY) Relationship to Patient ________________

Policy Owner's Employer ________________ Employer's Address ________________

Insurance Company ________________ Group No. (plan, local, or policy) ________________

Insurance Co. Address ________________ Insurance Phone No. ________________

Medical History

Are you under the care of a physician? Yes No If Yes, explain ______________________________

Physician ______________________ Phone ______________ Last Visit ______________

Address ____

Are you pregnant Yes No If so how many weeks ______________

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

Have you ever been evaluated for orthodontic treatment? Yes No

Have you tonsils or adenoids been removed? Yes No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever had an injury to : (select all that apply) Teeth Mouth Chin

Do you have speech problems? Yes No if Yes, explain ______________________________

Do your gums bleed? Yes No Do you smoke? Yes No Do you like your smile? Yes No

Does/Have you ever had any of the following habits?			
	Lip Sucking/Biting	Nail biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrusting	Thumb/ Finger Sucking

Are you allergic to any of the following?

Aspirin
Erythromycin
Codeine
Penicillin
Tetracycline
Latex
Any Metals/Plastics

Other Allergies/Sensitivites:

____

List all drugs you are currently taking

List any serious medical condition(s) treated

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form ______________________ Date ______________________

Mint Orthodontics

Peter An Truong, DDS, MS

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we always have and always will continue to respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another dental or medical health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your condition.
- We may have to disclose your health information or billing records to another party if they are responsible for the payment of your services.
- We may need to use your dental care information within our practice for implementation of office policy and procedures.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign your consent form. We reserve the right to change our privacy practices as described in that notice. If we make changes to our privacy practices, we will notify you in writing of any changes made.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place restrictions on the use or disclosure of your information, please let us know in writing. We are not required to agree to your restrictions; however if we do agree with your restrictions, the restrictions are binding on us.

Your Right To Revoke Your Authorization

You may revoke your consent to us at any time; however your revocation must be in writing. We will not be able to honor your revocation request if we have already released your information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to content any of your claims.

By submitting this form I acknowledge that I have read and understand this notice.