Patient Medical History

Patient's Name ______________________ Date of Birth ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

YES NO

1. Are you in good health ______
2. Have there been any changes in your general health within the past year ______
3. Date of your last physical exam ______
4. Physician's name ______
   Address ______
   Phone no. ______
5. Are you now under the care of a physician ______
6. Have you ever been hospitalized for any surgical operation or serious illness ______
   Please explain ______
7. Are you taking any medicine(s), including non-prescription medicine? ______
   If yes, what medicine(s) are you taking ______

YES NO

8. Have you had any abnormal bleeding ______
9. Do you bruise easily ______
10. Have you ever required a blood transfusion ______
11. Have you had a recent weight loss ______
12. Have you ever taken Fen-Phen or Redux ______
13. Do you use tobacco ______
14. Do you or have you used controlled substances ______
15. Are you wearing contact lenses ______
16. Do you have any disease, condition, or problem not listed above that you think I should know about ______

Women only:

Are you pregnant or think you may be pregnant ______
Are you nursing ______
Are you taking birth control pills ______

YES NO

Are you allergic to or have you had reactions to:

- Local anesthetics like novocaine ______
- Penicillin or other antibiotics ______
- Sulfa drugs ______
- Barbiturates, sedatives, or sleeping pills ______
- Aspirin ______
- Iodine ______
- Any metals (e.g., nickel, mercury, etc.) ______
- Latex/rubber ______
- Other (please list) ______

Do you have, or have you ever had, any of the following:

- Rheumatic heart disease or rheumatic fever ______
- Scarlet fever ______
- Heart defect or heart murmur ______
- Heart trouble, heart attack, or angina ______
- Chest pain ______
- Shortness of breath ______
- Pacemaker ______
- Heart surgery ______
- High/low blood pressure ______
- Congenital heart problem ______
- Swelling of feet, ankles, hands ______
- Hepatitis, jaundice, or liver disease ______
- Stroke ______
- Sinus trouble ______
- Lung or breathing problems ______
- Asthma or hay fever ______
- Hives or skin rash ______

YES NO

- Fainting or dizzy spells ______
- Diabetes ______
- AIDS or HIV infection ______
- Thyroid problem ______
- Allergies ______
- Arthritis or rheumatism ______
- Joint replacement or implant ______
- Stomach ulcer ______
- Kidney trouble ______
- Tuberculosis ______
- Persistent cough ______
- Cough that produces blood ______
- Chemotherapy (cancer, leukemia) ______
- Sexually transmitted disease ______
- Epilepsy or seizures ______
- Anemia ______
- Glaucoma ______
- Nervousness ______
- Tonsillitis ______
- Tumors ______
- Mental health care ______
- Back problems ______
- Chemical dependency ______
- Mitral valve prolapse ______
- Cortisone treatment ______
- Cold sores/fever blisters ______
- Hypoglycemia ______
- Eating disorders ______

Patient Medical History

Patient's Name ____________________ **Date of Birth** ____________

Reason for this visit ____________________

When was your last dental visit ____________ What was done then ____________

How often did you visit the dentist before then ____________________

Current dentist (name and location) ____________________

Have you had a complete series of dental exams (x-rays) taken? When and where ____________

How often do you brush your teeth ____________ How often do you floss your teeth ____________

Is your drinking water fluoridated ____________________

	YES	NO
Do your gums bleed while brushing or flossing		
Are your teeth sensitive to hot or cold liquids/foods		
Are your teeth sensitive to sweet or sour liquids/foods		
Do you feel pain to any of your teeth		
Do you have any sores or lumps in or near your mouth		
Have you had any head, neck, or jaw injuries		
Have you ever experienced any of the following problems in your jaw?		
Clicking		
Pain (joint, ear, side of face)		
Difficulty in opening or closing		
Difficulty in chewing		
Do you have frequent headaches		
Do you clench or grind your teeth		
Do you bite your lips or cheeks frequently		

	YES	NO
Have you noticed any loosening of your teeth		
Does food tend to become caught between your teeth		
Have you ever had periodontal treatment (gums)		
Ever worn a bite plate or other appliance		
Have you ever had any difficult extractions in the past		
Have you ever had any prolonged bleeding following extractions		
Do you wear dentures or partials		
If yes, date of placement		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums		
Have you had ortho/braces in the past		
Would you be interested in teeth whitening		
Have you had an unfavorable dental experience		

If you could do anything about your smile, what would you change? ____________________

____

____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____________________ Date ____________

Signature of patient or parent if minor

Doctor's Comments ____________________

____

____________ **Signature** ____________ **Date** ____________

____

Patient Number

Patient Information (Confidential)

Name ______________________________ Date __________
First Middle Last

Address __________ City __________ State __________ Zip __________

Cell # __________ Soc. security # __________ Birth date __________ Home phone __________

Email __________

Check Appropriate Box Minor Single Married Divorced Widowed Separated

If college student, F.T./P.T., name of school __________ City __________ State __________

Patient's or parent's employer __________ Work phone __________

Business address __________ City __________ State __________ Zip __________

Spouse or parent's name __________ Employer __________ Work phone __________

Whom may we thank for referring you __________

Person to contact in case of an emergency __________ Phone __________

Responsible Party

Name of person responsible for this account __________ Relationship to patient __________

Address __________ Home Phone __________

Driver's license # __________ Birth date __________ Soc. security # __________

Employer __________ Work phone __________

Is this person currently a patient in our office Yes No

Insurance Information

Name of insured __________ Relationship to patient __________

Birth date __________ Soc. security # __________ Date employed __________

Name of employer __________ Union or local # __________ Work phone __________

Employer address __________ City __________ State __________ Zip __________

Insurance co. __________ Tel. # __________ Grp. # __________ Policy/I.D. # __________

Ins. co. address __________ City __________ State __________ Zip __________

How much is your deductible __________ How much have you used __________ Max annual benefit __________

Do you have any additional insurance Yes No If yes, complete the following:

Name of insured __________ Relationship to patient __________

Birth date __________ Soc. security # __________ Date employed __________

Name of employer __________ Union or local # __________ Work phone __________

Employer address __________ City __________ State __________ Zip __________

Insurance co. __________ Tel. # __________ Grp. # __________ Policy/I.D. # __________

Ins. co. address __________ City __________ State __________ Zip __________

How much is your deductible __________ How much have you used __________ Max annual benefit __________

X ______________________________

Signature of patient or parent if minor

____

Patient number

NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003 (edition #1)
Fourth Dimension Orthodontics & Craniofacial Orthopedics

This notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review carefully.

YOUR PRIVATE HEALTHCARE INFORMATION (PHI)

Each time you have contact with a healthcare provider for delivery of healthcare a record of your contact/ visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/ symptoms, results of examination and tests, diagnoses, treatment and future care. Your medical record is the physical property of Fourth Dimension Orthodontics & Craniofacial Orthopedics("Fourth Dimension Orthodontics"), but you have certain rights to restrict some of the use or disclosures of the information in your medical records. Fourth Dimension Orthodontics however, has the right to use and disclose the information contained in your medical record in the process of providing treatment, receiving payment and performing other regular healthcare operations such as;

Documenting and describing the care you receive for legal purposes.
Communicating with the other healthcare providers who may be involved in your care.
Educating healthcare professionals.
Medical research.
Providing information for government and public health entities responsible for improving public health and welfare.
Evaluating and improving the care you receive and the outcomes achieved.
Billing and verification of services provided to you.
Conducting other routine healthcare operations such as quality improvement studies and assessing healthcare provider competence.

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of Fourth Dimension Orthodontics and are required by law to maintain privacy and confidentiality of your health information, provide you with this **Notice of Privacy Practices,** notify you of your rights to restrict use of this information, notify you if Fourth Dimension Orthodontics is unable to agree to a requested restriction, and allow you to review the **Notice of Privacy Practices** prior to granting consent and notifying you of changes/revisions to this notice.

EXAMPLES OF DISCLOSURE OF YOUR PRIVATE HEALTHCARE INFORMATION(PHI)

Healthcare delivery and treatment:
Information obtained from you by a physician, physician assistant, nurse or other healthcare professional is documented in your record and used for assessment, evaluation, diagnosis and treatment of medical condition(s). This information is provided to other healthcare professionals, such as physicians, specialists, physical therapists, hospital based providers and/or other healthcare providers following your treatment by Fourth Dimension Orthodontics.

Billing and Payment
Your PHI is utilized to justify the level of care delivered to you and the charges incurred for the services. This information generally accompanies the bill and is sent to our payers and other third party administrators.

Other Healthcare Operations
Fourth Dimension Orthodontics may disclose your PHI to other individuals and businesses in order for Fourth Dimension Orthodontics to perform their day to day operations. These other individuals and businesses included associates such as vendors and/or contractors used for credentialing and peer review, patient satisfaction surveys, utilization review/utilization management, billing and claims

management, medical research, disease management and quality improvement initiatives, as well as management service organizations, laboratories, free standing diagnostic facilities and legal counsel. Fourth Dimension Orthodontics requires all its business associates to agree to appropriately protect the confidentiality of your PHI.

Reminders and Treatment
Fourth Dimension Orthodontics may contact you to provide you with information that we feel is useful or helpful to you based on your PHI. For example, Fourth Dimension Orthodontics may contact you (or instruct a specialist physician to whom you have been referred to contact you) to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information (Lab results, X-Rays) on treatments you are already receiving.

Other Users and Disclosures
Fourth Dimension Orthodontics may also utilize or disclose your PHI in order to communicate with or notify family members, relatives, others responsible for your health and funeral directors. In additions, Fourth Dimension Orthodontics may disclose your PHI through other communication and reports required to be made by healthcare professionals such as public health department, law enforcement, the Food and Drug Administration, organ procurement organizations, correctional institutions and workers compensations, where applicable.

Other users and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that Fourth Dimension Orthodontics has already taken action in reliance on your prior authorization.

YOUR RIGHTS CONCERNING PHI

Except as otherwise provided by law, you have the right to:
Receive a paper copy of this **Notice of Privacy Practices.**
Receive confidential communications of PHI if a request is submitted in writing.
Obtain a copy of PHI or records about you in a designated record set as long as the PHI is maintained in the record set.
Ask Fourth Dimension Orthodontics to amend PHI or records about you in a designated record set as long as the PHI is maintained in the record set (Fourth Dimension Orthodontics is not required to change the information if it deems it to be accurate).

Receive an accounting of disclosures of PHI (a list of the disclosures made by Fourth Dimension Orthodontics about you for reasons other than for treatment, payment or healthcare operations); and request that Fourth Dimension Orthodontics restrict uses of disclosures of your PHI other than for treatment, payment or healthcare operations. Though Fourth Dimension Orthodontics is not required to agree to a restriction to the extent that it does not agree with your request, Fourth Dimension Orthodontics may not disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law.

Fourth Dimension Orthodontics is required by law to abide by the terms of this **Notice of Privacy Practices,** allow you to receive this **Notice** prior to grating consent, and to notify you of changes/revisions of this notice. If you believe your privacy rights have been violated, you may submit a written complaint to Fourth Dimension Orthodontics of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. Fourth Dimension Orthodontics will not retaliate against you in any way for filling a complaint.

NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003 (edition #1)
Fourth Dimension Orthodontics & Craniofacial Orthopedics

FOURTH DIMENSION ORTHODONTICS & CRANIOFACIAL ORTHOPEDICS
7777 FOREST LANE SUITE C-770
DALLAS, TX 75230
972-566-3100

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Fourth Dimension Orthodontics & Craniofacial Orthopedics, ("Fourth Dimension Orthodontics"), **Notice of Privacy Practices** ("Notice"):

* It tells me how Fourth Dimension Orthodontics will use my health information for the purposes of my treatment, payment for my treatment and Fourth Dimension Orthodontics health care operations.

* The Notice explains in more detail how Fourth Dimension Orthodontics may use and share my health information for other reasons than treatment, payment and health care operations.

* Fourth Dimension Orthodontics will also use and share my health information as required/permitted by law.

Patients Complete Legal Name:____
(please print)

Patient's Date of Birth:____

Signature:_______________________________________ Date:_______________

(Patient or legal representative*)
*May be requested to show proof of representative status