

ADULT PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out both sides of form.

Patients Name _____ Age _____ Birthdate _____ Sex _____
Address _____
Home Phone _____ Cell Phone _____
Employer _____ Business Phone _____
Occupation _____ E-mail _____
Marital Status _____

Person(s) responsible for financial matters

Name(s) _____	Name(s) _____
Address _____	Address _____
City, State _____	City, State _____
Home Phone _____	Home Phone _____
Business Phone _____	Business Phone _____
Place of Employment _____	Place of Employment _____
Social Security Number _____	Social Security Number _____

Are you covered by insurance for orthodontic treatment? ☐ No ☐ Yes

If yes, by which company? _____

	Family Dentist	Family Physician	Referred By
Name	_____	_____	_____
Address	_____	_____	_____
City, State	_____	_____	_____
Your interests and hobbies	_____		

Reason for orthodontic consultation? _____

Has anyone in your family had a similar problem? _____

Are you self-conscious about your teeth? _____

MEDICAL HISTORY – Have you ever had any of the following? (please check off)

- | | | | | |
|------------------------------------|--|--|---|---|
| ☐ AIDS | ☐ Bleeding | ☐ Emotional Problems | ☐ Hepatitis | ☐ Previous Surgery |
| ☐ Allergy | ☐ Bone Loss / Disorders | ☐ Epilepsy / Seizures | ☐ Herpes | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Cold Sores | ☐ Hearing Problems | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Arthritis | ☐ Diabetes | ☐ Heart Condition | ☐ Lung Disease | ☐ Other (describe below) |
| ☐ Asthma | ☐ Endocrine Problems | ☐ Head or Face Injuries | ☐ Oral Ulcer | |

Comments _____

Have you been under the care of a physician during the past two years, other than for routine examinations? ☐ No ☐ Yes

Condition _____

Date of last medical exam _____

Do you require antibiotic premedication for dental procedures? ☐ No ☐ Yes

Present drugs or medications _____

Birth Defects _____

Patient's Height _____ Patient's Weight _____

RESPIRATORY HISTORY

Do you:

1. Have allergies to: Drugs: _____ Food: _____

Seasonal Grasses: _____ Other: _____

2. Breathe through mouth? ☐ Seldom ☐ Sometimes ☐ Usually

3. Snore when sleeping? ☐ No ☐ Yes

4. Have frequent colds? ☐ No ☐ Yes

5. Have frequent "Stuffy Nose"? ☐ No ☐ Yes

6. Have frequent sore throat or tonsillitis? ☐ No ☐ Yes

7. Have chewing or swallowing difficulty? ☐ No ☐ Yes

Have you received medical treatment from an allergist or ear, nose and throat specialist? ☐ No ☐ Yes

If yes: When _____ By Whom _____

Nasal Surgery _____ Tonsils removed _____ Adenoids removed _____

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Have you had any unusual dental experiences? ☐ No ☐ Yes

Specify _____

Date of last dental checkup _____ Were your teeth cleaned? ☐ No ☐ Yes

Have you had an orthodontic consult or treatment? ☐ No ☐ Yes

Do you have Headaches? _____ Neck Pain? _____ Jaw Pain? _____ Ear Pain? _____ Face Pain? _____ Eye Pain? _____ Other? _____

Which side hurts? Right _____ Left _____ Both _____

How long have you had these symptoms? _____ years _____ days _____ months

Is the pain constant? _____ aching? _____ shooting? _____ burning? _____ stabbing? _____ electrical? _____ other? _____

Worse in the afternoon? _____ Worse in the morning? _____ Does it hurt to chew? _____ Does it hurt to open wide? _____

Does your jaw make a popping noise? _____ clicking? _____ grinding? _____ other? _____

Has your jaw ever "locked" or slipped out of place? _____

Do you ever clench or grind your teeth? _____ During the day? _____ During the night? _____

Do you have problems with your ears? _____ Hearing? _____ Dizziness? _____ other? _____

Is it difficult to swallow? _____ Painful? _____

Are your teeth sore or sensitive? _____

Additional comments _____

Signature _____ Date _____



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the Notice of Privacy Practices as allowed by law.
- The practice has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Please read and review our notice before signing this consent.

I have received and reviewed a copy of the Notice Of Privacy Practices.

Print name of Patient

Parent/Guardian Signature

Date

Witness Signature

Date



Individual Release Agreement

Pennington Orthodontics & Pediatric Dentistry

The undersigned enters into this agreement with Pennington Orthodontics & Pediatric Dentistry, and Associates (Producer). I have been informed and understand the above dental office will be using my photographs (product), for marketing purposes.

- 1 I grant Producer, the right to use the product and my name whether recorded on or transferred to videotape, film, slides, other photographs, audiotapes, or other media, now known or later developed. This grant includes without limitation the right to edit, mix, or duplicate and to use or re-use the product in whole or part as Producer, may elect. Producer will have complete ownership of the product in which I appear, including copyright interest, and I acknowledge that I have no interest of ownership in the resulting product or it's copyright.
- 2 I also grant Producer, and its designees the right to broadcast, exhibit, market, sell, and otherwise distribute the product, either in whole or in parts, and either alone or with other products, for advertising allowing Producer or its designees their sole discretion to determine its use. This grant includes the right to use the product for promoting or publicizing any of the uses.
- 3 I confirm that I have the right to enter into this agreement, that I am not restricted by any commitments to third parties, and that producer has no financial commitment or obligations to me as a result of this agreement, I hereby give all clearances, copyright and otherwise, for use of my name, likeness, image appearance and performance embodied in the product. I expressly release and indemnify producer and its officers, employees, agents and designees, from any and all claims known and unknown arising out of or in any way connected with the above granted uses and representations, the rights granted producer herein are perpetual and worldwide.
- 4 Inconsideration of all of the above, I hereby acknowledge receipt of reasonable and fair consideration from producer.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

OR

I **decline** any photographs for social/ electronic media use: ☐



Our 'No Show' Policy

To ensure that each patient is given the proper amount of time for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

A NO SHOW fee is charged when you miss your scheduled appointment in the amount of \$75.00 if the appointment is not cancelled within 48 hours prior to the appointment.

Thank You!

Para asegurar que cada paciente reciba la cantidad de tiempo adecuada para su visita y para proporcionar la atencion de mas alta calidad, es muy importante asistir a su visita a tiempo.

UN CARGO se cobrara cuando se pierde su cita por la cantidad de \$75.00 si no ha sido cancelada dentro de 48 horas antes de la cita.

Gracias!

Name on card: _____

Card number: _____

Billing address: _____

Patient/Guardian Signature: _____ Date: _____