Jackson Orthodontics
Miriam T. Furlong, DMD, pc
732-942-8400

Patient's Last Name: _____ First Name: _____MI: __ Nickname: _____

Birth Date:_____Age:_____Sex:_____

Home Address:_____

(H) Phone: _____ (C) Phone:_____

Responsible Party Information: (person responsible for account)

Last Name:_____First Name:_____

Relation to Patient:_____

Marital Status: (Circle) S M D Sep W

Social Security #:_____ Birth Date:_____

(H) Phone: _____ (C) Phone:_____(W) Phone: _____E-mail:_____

Home Address:_____ **(Circle: OWN or RENT)**

How long at this address: _____ *if less than 3-year, previous address: _____

Employer:_____ Occupation: _____Years Employed: _____

Dental insurance info: Subscriber's name:_____ DOB: _____

Insurance Co. name: _____ID: _____

GRP#/Local #:_____

Spouse Information:

Last Name: _____ First Name: _____Relationship to Patient: _____
(H) Phone: _____ (C) Phone: _____ (W) Phone: _____

Social Security #: _____ Birth Date: _____
Employer: _____ Occupation: _____ Yrs. Employed: _____

Dental insurance info: Subscriber's name:_____ DOB: _____
Insurance Co. name:_____ ID: _____ GRP#/Local #:_____

Signature: _____
(I understand that where appropriate, credit bureau report will be obtained)

Patient's Last Name:_____ **First Name:**_____**Birth Date:**_____

School: _____ Grade: _____ Sports/Hobbies/Musical Instruments: _____

Siblings/ages: _____

DENTAL HISTORY:

Dentist: Phone:

Date last seen: Reason:

Now or in the past, has the patient had: **Describe:**

Y N U Chipped or injured primary (baby) or permanent teeth?

Y N U "Gum boils", frequent canker sores or cold sores?

Y N U Thumb or finger sucking habit? Until what age?

Y N U Abnormal swallowing or tongue thrust habit?

Y N U History of speech problems?

Y N U Mouth breathing, snoring, or difficulty breathing?

Y N U Tooth grinding or jaw clenching?

Y N U Treatment for "TMJ" problems or "TMD"?

Y N U Concerned about spaced, protruding or crooked teeth?

Y N U Aware or concerned about under or over developed jaw?

Y N U Any relative with similar tooth or jaw relationships?

Y N U Unusual dental condition?

Main concern:

MEDICAL HISTORY: Answer every question by circling Y (yes) N (no) U (unsure) your answers are for office records only and are confidential.

Patient's Physician: Phone:

Date last seen: Reason:

Y N U Operations, hospitalizations and or accidents?

(if yes) explain:

Y N U Any life-threatening or serious medical conditions?

(if yes) explain:

Y N Is patient adopted?

Y N U Medical condition that requires medication before dental treatment?

(if yes) explain/list:

Taking medications for? (List): _____

Was the patient ever diagnosed with the following?

Y N U Birth defects or hereditary problem?

Y N U Tonsil or adenoid condition- removed?

Y N U Learning or behavior disorder?

Y N U Any life-threatening allergies?

(if yes) do you carry medication in case of exposure?

Females only: Y N U Did patient begin menstruation? if yes at what age?

Y N U Is the patient pregnant?

Males only: Y N U Did puberty begin: if yes, what age?

Allergies:

Y N U Latex (gloves, balloons)

Y N U Metals (jewelry, clothing snaps)

Y N U Acrylic or Vinyl

Y N U Other sensitivity to materials or foods

Habits:

Y N U Tobacco, Smoking or chewing

Y N U Other substance abuse

Emergency Contact Information:

Name of nearest relative not living with you: _____Relationship to Patient: _____

Address: _____ Phone:_____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later of this history record or medical/dental status, I will so inform the practice.

Signed (Parent/Guardian) **Date**

Dr/Staff member **Date**

Insurance Signature on file form for Electronic Submission of Insurance

Date: _____

Patient Name (print)" _____

Subscriber's Name (print): _____

Relationship to patient: _____

Benefits: Our office strives to give the most accurate benefit information from the telephone verification we receive from your insurance company. Information given to our office is not a guarantee of coverage. Benefits may only be determined after claims are processed for payment. You are responsible for any unpaid insurance balance.

Signature on file: I have been informed of the treatment and the associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above-named dentist or dental entity.

Subscriber's Signature: _____

PRIVACY CONSENT NOTICE

Patient's Last Name:_____**First Name:**_____Birth **Date:**_____

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PRIOR TO COMMENCING YOUR ORTHODONTIC TREATMENT, PLEASE REVIEW, SIGN, AND DATE THIS FORM.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, our internal staff, etc.) who have any role in your treatment?
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information; however we are not required to, and may not honor your request.
- Request confidential communication of your protected health information;
- Amend or modify your protected health information in certain circumstances (unless it is accurate and complete).
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and human Services (which must be filed within 180 days of the violation).

This privacy notice is effective as of the date of your signature. Thank you for your cooperation. Please let us know if you have any questions.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Consent Notice.

_____

Patient (If minor, Guardian Signature) Date:_____