Registration and Medical History – Adult Consult Date

Patient's Last Name First Name M.I

Preferred name/nickname

Birth Date Age Sex: M / F Marital status: S M D W

Home Phone Cell Phone Work Phone Email:

Complete Home Address

E-mail

Family members treated here

Name of Patient's Dentist Phone

Address:

Date last seen Reason

Who suggested that your child might need orthodontic treatment?

Why did you select our office?

Main concern:

Patient's Physician Phone

Date last seen Reason

Emergency Contact Information:

Name of nearest relative not living with you: Relationship:

Address: Phone:

MEDICAL HISTORY: Answer every question by circling Y (yes) N (no) U (unsure)

Was the patient ever diagnosed with the following? Taking medications for?(list)

Y N U Birth defects or hereditary problem?
Y N U Bone fractures or major accident?
Y N U Rheumatoid or arthritic conditions?
Y N U Endocrine or thyroid problems?
Y N U Kidney problems?
Y N U Diabetes?
Y N U Cancer, tumor, radiation or chemo treatment?
Y N U Stomach ulcer or hyperacidity?
Y N U Polio, mononucleosis, tuberculosis or pneumonia?
Y N U Immune system problems?
Y N U AIDS or HIV?
Y N U Hepatitis, Jaundice, or liver problems?
Y N U Fainting spells, seizures, epilepsy or neurological problems?
Y N U Mental health disturbance or depression?
Y N U Vision, hearing, tasting or speech difficulties?
Y N U Rapid unintentional weight loss, loss of appetite?
Y N U Eating disorder, anorexia, bulimia?
Y N U High or low blood pressure?
Y N U Unusually tired or chronic fatigue?
Y N U Chest pain, shortness of breath or ankle swelling?
Y N U Cardiovascular problem (heart trouble, angina, stroke, heart defect?)
Y N U Heart murmur that requires antibiotic premedication for dental visits?
Y N U Skin disorder?
Y N U Frequent headaches, colds or sore throat?
Y N U Eye, ear, nose or throat condition?
Y N U Hayfever, asthma, sinus trouble or hives?
Y N U Tonsil or adenoid condition?

Allergies or reactions to any of the following?:

Y N U Latex (gloves, balloons)
Y N U Metals (jewelry, clothing snaps)
Y N U Acrylic or Vinyl
Y N U Foods
Y N U Animals
Y N U Other

Y N U Ibuprofen (Motrin, Advil)
Y N U Aspirin
Y N U Penicillin or other antibiotics
Y N U Sulfa drugs
Y N U Codeine or other narcotics
Y N U Local anesthetics (Novacaine)

Other History and Habits:

Y N U Tobacco smoking or chewing
Y N U Other substance abuse
Y N U Operations
Y N U Hospitalizations
Y N U Other physical problems
Describe

Family History:

Y N U Jaw size imbalance
Y N U Bleeding disorders
Y N U Diabetes
Y N U Arthritis
Y N U Severe allergies
Y N U Unusual dental problems

Females only: Y N U Is the patient pregnant?

PATIENT PROFILE:

Y N U Is the patient excited about the possibility of wearing braces?

Y N U Does the patient brush his/her teeth thoroughly? Floss? How often?

Y N U Does the patient need extra help with instructions?

Y N U Is the patient self-conscious about his/her teeth?

DENTAL HISTORY: Answer every question by circling Y (yes) N (no) U (unsure)

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

Y N U Permanent or "extra" teeth removed?

Y N U Supernumerary (extra) or congenitally missing teeth?

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

Y N U Teeth sensitive to hot, cold; teeth throb or ache?

Y N U Jaw fractures, cysts or mouth infections?

Y N U "Dead teeth" or root canals?

Y N U Any periodontal (gum) problems? Bleeding Odor Bad taste

Y N U Food impaction between 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 Pain/difficulty chewing, jaw opening, clicking, or ringing in the ears?

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

Y N U Aware of loose, broken, or missing restorations (fillings)?

Y N U Any teeth irritating cheek, lip, tongue or palate?

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 Any wisdom tooth problems?

Y N U Had any serious trouble associated with previous dental treatment?

Y N U Been under another dentist's care? Specialist?

Y N U Ever had a prior orthodontic examination or treatment?

Y N U Would patient object to wearing braces should they be indicated?

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**

PRIVACY CONSENT NOTICE

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

Jackson Orthodontics

Miriam T. Furlong, DMD, pc
732-942-8400
jacksonorthodontics.com

Date_____

CONFIDENTIAL PATIENT INFORMATION **Please fill out form completely. Thank you**

Patient's Last Name_____First_____Middle_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Birth date _____

If Patient is a minor, give parent or guardian name_____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION: **(Person Responsible for the account)**

Last Name _____First_____Middle_____

Marital Status Single Married Separated Divorced Widowed

Street Address_____City_____State_____Zip_____

Own_____ Rent_____ Live with parents_____

How long at this address? _____

*If less than 3 years, previous address _____

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security#_____

Birth date_____ Relationship to Patient_____

Employer_____ Occupation (Your jobtitle)_____

Years Employed _____

SPOUSE Last Name_____ First Name_____Middle_____

Home Phone _____Work Phone _____Cell Phone _____

Social Security #_____

Birth date _____ Relationship to Patient _____

Employer_____ Occupation (Job title)_____

Years Employed_____

Insurance Information:

Primary Policy Holder_____DOB_____SS#_____

Insurance company_____ID#_____Group #_____

Employer _____ Union Local#_____

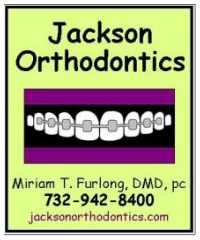
Secondary Policy Holder_____DOB_____SS#_____

Insurance company_____ID#_____Group #_____

Employer_____Union Local#_____

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parents signature if minor)_____



Jackson Orthodontics Insurance Policy:

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.

_____/**Patient Name (print)**
_____/**Subscriber's Name** **Relationship to patient** _____
_____/**Print Name** _____-_____-_____/**Date**

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**