Medical Dental History For Adults

CONFIDENTIAL

Date_____

Patient

Patient's last name_____ First name_____ Middle Initial _____

Prefers to be called_____ Gender (check all that apply) □Male □Female

Date of Birth_____ Identifies as (check all that apply) □Male □Female □Nonbinary

Mailing address_____ City, State, Zip Code_____

Home phone ( ) _____-_____Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Email address _____

Occupation _____ Employer _____

Financial Responsibility

Who is financially responsible for this account? _____

Mailing address_____

Home phone ( ) _____-_____Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Dentist

Patient's dentist_____ Address, City, State_____

Last seen_____ Reason_____

Physician

Patient's physician_____Address, City, State_____

Dental Insurance

Primary policy holder's full name_____Date of birth_____

Social Security #_____ Relationship to patient_____

Address (if not listed above) _____ Phone (if not listed above) ( )_____-_____

Employer_____ Address_____

Insurance Company_____ Patient ID#_____ Group #_____

Secondary policy holder's full name_____ Date of birth_____

Social Security #_____ Relationship to patient_____

Address (if not listed above) _____ Phone (if not listed above) ( )_____-_____

Employer_____ Address_____

Insurance Company_____ Patient ID#_____ Group #_____

Medical History

Please check the following, if they apply:

□Head or facial injury □Glaucoma

□Heart trouble □Heart murmur

□Tonsil/adenoid problems □Asthma

□Diabetes □Kidney disease

□Hepatitis/Liver disease □Epilepsy

□High blood/low pressure □Endocrine problems

□Immune system problems □HIV or AIDS

□Mental health problems □Speech problems

□Bleeding problems □Rheumatic fever

Allergies or reactions to any of the following?

Yes No

□ □ Local anesthetics (novocaine, lidocaine, xylocaine)

□ □ Latex (gloves, balloons)

□ □ Aspirin

□ □ Ibuprofen (Motrin, Advil)

□ □ Penicillin or other antibiotics

□ □ Metals

□ □ Acrylics

□ □ Plant pollens

□ □ Animals

□ □ Foods

□ □ Other

Dental History

Yes No

□ □ Erupting teeth very early or very late?

□ □ Baby teeth removed that were not loose?

□ □ Permanent or extra teeth removed?

□ □ Chipped or injured primary or permanent teeth?

□ □ Sensitive or sore teeth?

□ □ Bleeding gums, bad taste, or mouth odor?

□ □ Lost or broken fillings?

□ □ Jaw fractures, cysts, or infections?

□ □ Any teeth treated for infection?

□ □ Frequent canker sores or cold sores?

□ □ History or speech problems or speech therapy?

□ □ Mouth Breathing habit or snoring at night?

□ □ Finger sucking?

□ □ Teeth irritating lips, cheeks, or gums?

□ □ Tooth grinding or clenching?

□ □ Clicking or locking in jaw joints?

□ □ Been treated for “TMJ” or “TMD” problems?

□ □ Previous complications with dental treatment?

□ □ Have you ever had an orthodontic consultation or treatment?

□ □ Have you noticed changes in your face or jaws?

Patient Health Information

List any medication, nutritional supplements, or non-prescription medicines that your child takes.

Medication_____ Taken for_____

Medication_____ Taken for_____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you take antibiotic pre-medication before any dental procedures? _____

Do you chew or smoke tobacco? □ Yes □ No

Women: Are you pregnant? □ Yes □ No Are you trying to become pregnant? □ Yes □ No

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental insurance company as well as other dental professionals for the purpose of evaluating and treating.

Signature_____ Date_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature_____ Date_____

I authorize Dr. Douglas Laliberte to take a CBCT scan as well as photographs for the purpose of evaluating the teeth, jaw and the surrounding bone. I understand that these will be used by Granite Coast Orthodontics for those limited purposes and that Dr. Laliberte is not a trained pathologist or radiologist.

Signature_____ Date_____

You may refuse this scan If refusing sign: _____ Date_____

At an additional cost of $135 we can have your CBCT scan read by a board certified Oral and Maxillofacial Radiologist can evaluate.

□**Yes**, I want my CBCT scan read by an oral radiologist. I understand that I am responsible for the cost of this, $135.

□**No,** I understand the risks and benefits of having my CBCT read and interpreted by an oral radiologist. However, I am declining this service, at this time.

HIPAA Notice of Privacy Practices

Granite Coast Orthodontics, LLC, PA

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ AND REVIEW CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist/physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

We will also disclose to a family member, spouse, or adult children information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extent necessary to help with your healthcare and/or with payment for your healthcare.

For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you. An another example would be when we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information to dental/hygiene students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician/dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. **We will not retaliate against you for filing a complaint.**

This notice was published and became affected on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number 815-444-0000.

I, _____, have received a copy of the above Notice of Privacy Practices from this office and give my permission to all of the above.

_____ Date: _____

Please Print Name

_____ Date: _____

Signature

You may refuse to sign this acknowledgement

If refusing: _____ **Date:** _____

Signature