CONFIDENTIAL

# Medical Dental History Form for Adult Patients

## PATIENT

Date _____

Patient's Last name _____ First name _____ Middle initial _____

Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other _____ I prefer to be called _____

Birth date _____ Sex: ☐ Male ☐ Female Social Security # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address _____ City, State, Zip code _____

Cell phone _____ Home phone _____

Work phone _____

E-mail address(es) _____

Occupation _____ Employer _____

## CLOSEST RELATIVE

Spouse or closest relative's name(s) _____

Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other _____ Relationship to patient _____

Address *(if different than patient address)* _____

Cell phone _____ Home phone _____

Work phone _____

## DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason_____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

## PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____

## GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment?_____

Why did you select our office?_____

Have you had any previous orthodontic treatment? Please describe_____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

## FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (*if different from page 1*)_____ City, State, Zip _____

Cell phone _____ Home phone _____

E-mail address(es) _____

Social Security #_____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments?_____

## DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

Secondary policy holder's full name _____ Birthdate _____

Social Security #_____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

## MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

*Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (dk/u).*

## MEDICAL HISTORY

### Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?

☐ yes ☐ no ☐ dk/u Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

☐ yes ☐ no ☐ dk/u Birth defects or hereditary problems?
☐ yes ☐ no ☐ dk/u Bone fractures, or major injuries?
☐ yes ☐ no ☐ dk/u Any injuries to face, head, neck?
☐ yes ☐ no ☐ dk/u Arthritis or joint problems?
☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?
☐ yes ☐ no ☐ dk/u Diabetes or low sugar?
☐ yes ☐ no ☐ dk/u Kidney problems?
☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dk/u Stomach ulcer, hyperacidity, acid reflux?
☐ yes ☐ no ☐ dk/u Immune system problems?
☐ yes ☐ no ☐ dk/u History of osteoporosis?
☐ yes ☐ no ☐ dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐ yes ☐ no ☐ dk/u AIDS or HIV positive?
☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or other liver problem?
☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐ yes ☐ no ☐ dk/u Seizures, fainting spells, neurologic problem?
☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?
☐ yes ☐ no ☐ dk/u Vision, hearing, or speech problems?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dk/u High or low blood pressure?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising, anemia?
☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
☐ yes ☐ no ☐ dk/u Heart defects, heart murmur, rheumatic heart disease?
☐ yes ☐ no ☐ dk/u Angina, arteriosclerosis, stroke or heart attack?
☐ yes ☐ no ☐ dk/u Skin disorder (other than common acne)?
☐ yes ☐ no ☐ dk/u Do you eat a well-balanced diet?
☐ yes ☐ no ☐ dk/u Frequent headaches or migraines?
☐ yes ☐ no ☐ dk/u Frequent ear infections, colds, throat infections?
☐ yes ☐ no ☐ dk/u Asthma, sinus problems, hayfever?
☐ yes ☐ no ☐ dk/u Tonsil or adenoid condition?
☐ yes ☐ no ☐ dk/u Do you frequently breathe through your mouth?

### Have you had allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Acrylics
☐ yes ☐ no ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐ yes ☐ no ☐ dk/u Aspirin
☐ yes ☐ no ☐ dk/u Ibuprofen (Motrin, Advil)
☐ yes ☐ no ☐ dk/u Penicillin
☐ yes ☐ no ☐ dk/u Other antibiotics
☐ yes ☐ no ☐ dk/u Plant pollens
☐ yes ☐ no ☐ dk/u Animals
☐ yes ☐ no ☐ dk/u Foods
☐ yes ☐ no ☐ dk/u Other substances _____

## DENTAL HISTORY

### Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Permanent or extra (supernumerary) teeth removed?
☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
☐ yes ☐ no ☐ dk/u Chipped or injured primary or permanent teeth?
☐ yes ☐ no ☐ dk/u Any sensitive or sore teeth?
☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or mouth odor?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts, infections?
☐ yes ☐ no ☐ dk/u Any teeth treated with root canals or pulpotomies?
☐ yes ☐ no ☐ dk/u "Gum boils," frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u History of speech problems or speech therapy?
☐ yes ☐ no ☐ dk/u Difficulty breathing through nose?
☐ yes ☐ no ☐ dk/u Food impaction between the teeth?
☐ yes ☐ no ☐ dk/u Mouth breathing habit or snoring at night?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
☐ yes ☐ no ☐ dk/u Teeth causing irritation to lip, cheek or gums?
☐ yes ☐ no ☐ dk/u Abnormal swallowing (tongue thrust)?
☐ yes ☐ no ☐ dk/u Tooth grinding or clenching?
☐ yes ☐ no ☐ dk/u Clicking, locking in jaw joints?
☐ yes ☐ no ☐ dk/u Soreness in jaw muscles or face muscles?
☐ yes ☐ no ☐ dk/u Ringing in ears, difficulty in chewing or opening jaw?
☐ yes ☐ no ☐ dk/u Have you ever been treated for "TMJ" or "TMD" problems?
☐ yes ☐ no ☐ dk/u Any broken or missing fillings?
☐ yes ☐ no ☐ dk/u Any serious trouble associate with previous dental treatment?
☐ yes ☐ no ☐ dk/u Have you ever been diagnosed with gum disease or pyorrhea?
☐ yes ☐ no ☐ dk/u Have you ever had an orthodontic consultation or treatment before now

## PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Medication _____ Taken for _____ Medication _____ Taken for _____

Medication _____ Taken for _____ Medication _____ Taken for _____

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

Do you or have you ever had a substance abuse problem? _____

Have you chewed tobacco ☐ Yes ☐ No or smoked any substance or vaped? ☐ Yes ☐ No

If yes, what is the frequency? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush?_____ How often do you floss?_____

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

## FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

## RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

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_____

## MEDICAL HISTORY UPDATES OR CHANGES

Changes _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____

Changes _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____

Changes _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____

# LUFF ORTHODONTICS PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations.

**PROTECTING PERSONAL HEALTHCARE INFORMATION**

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Alaska. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

**COLLECTING PERSONAL HEALTHCARE INFORMATION**

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

**DISCLOSING PERSONAL HEALTHCARE INFORMATION**

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal protected information in exchange for or receipt of financial remuneration.

Any branch in the protection of your personal health information including unauthorized acquisition, access, use, or disclosure will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your PHI.

**YOUR RIGHTS AS OUR PATIENT**

You have a right to request copies of your healthcare information in a variety of formats and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other that stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. We urge you to notify us immediately if you believe your rights have been violated. You can also notify the U.S. Department of Health and Human Services.

An expanded and complete copy of our Statement of Privacy Practices is available for your review.

**Additional Disclosure Authorization:** I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Luff Orthodontics. In addition to the allowable disclosures describes in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indication "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules).

PRINT PATIENT NAME _____ DATE OF BIRTH _____

PRINT RESPONSIBLE PARTY NAME (OVER 18 YEARS OLD) _____ DATE OF BIRTH _____

RESPONSIBLE PARTY SIGNATURE _____

TELEPHONE _____ TODAY'S DATE _____

| PLEASE INDICATE AUTHORIZED PERSONS | CIRCLE ONE | |
|---|---|---|
| Patient's Immediate Family<br>Example parents, children | YES | NO |
| Patient's Extended Family<br>Example grandparents, grandchildren | YES | NO |
| Patient's Spouse (if applicable) | YES | NO |
| Other (please list name below) | YES | NO |

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