Waterford Orthodontics

4104 Dublin Blvd. Suite E **T: (925)803-9800**

Patient Biographical Information

First Name:	Middle Initial:	Last Name:	Date of Birth:
Nickname:	Male ☐ Female ☐	Social Security #:	
Address:	City:	State	Zip Code:
Home Phone:	Cell phone:	Email:	
Please List the names of any friends or family currently in the practice:			Referred By:
List any Sports, hobbies, or musical instruments played:			Nickname:

Financial Party Information

First Name:	Middle Initial:	Last Name:	Date of Birth:
Address:	City:	State:	Zip Code:
Home Phone:	Cell phone:	Social Security #:	
Occupation:	Employer:	Email:	
Length of Employment:	Work Phone:	Relationship to patient:	

Primary Insurance:		**Secondary Insurance:**	
Subscriber Name:	Date of Birth:	Subscriber Name:	Date of Birth:
Insurance Name:	Ins. Address:	Insurance Name:	Ins. Address:
SSN or ID#:	Group #:	SSN or ID#:	Group #:
Employer:	Relationship to Patient:	Employer:	Relationship to Patient:

Dental History (Please circle Yes or No if any of the following questions apply)

Name of Current Dentist:		**Dentist Phone Number:**	
Speech problems/therapy?	☐Yes ☐No	Brush teeth daily?	☐Yes ☐No
Grind or clenching teeth?	☐Yes ☐No	Floss teeth daily?	☐Yes ☐No
Oral habits (thumb/finger Habit, Lip/ Nail Biting?	☐Yes ☐No	Fluoride treatment?	☐Yes ☐No
Injury to face, jaw, teeth or mouth?	☐Yes ☐No	Mouth breathing?	☐Yes ☐No
Discomfort from teeth or gums?	☐Yes ☐No	Snores during sleep?	☐Yes ☐No
Pain, tenderness, or noise in either jaw?	☐Yes ☐No	Requires Antibiotic premedication?	☐Yes ☐No
Frequent headaches?	☐Yes ☐No	Any missing/extra permanent teeth?	☐Yes ☐No
Neck/Shoulder pain?	☐Yes ☐No	Apprehensive about Dental Care?	☐Yes ☐No
Frequent sore throats?	☐Yes ☐No	Frequently chews gum?	☐Yes ☐No

If any of the above dental questions were answered "Yes", please explain:

Health History

Physicians Name:	Date of Last Physical:	Patients Health:

Address:	City:	State	Zip Code:

Rheumatic fever	☐Yes ☐No	Cancer	☐Yes ☐No
Tuberculosis or persistent cough	☐Yes ☐No	Family History of Cancer	☐Yes ☐No
Pneumonia	☐Yes ☐No	Received Radiation Treatment	☐Yes ☐No
Liver Disease	☐Yes ☐No	Growth Problems	☐Yes ☐No
Kidney Disease	☐Yes ☐No	Endocrine Problems	☐Yes ☐No
Heart Attack/Stroke	☐Yes ☐No	Hormone Therapy	☐Yes ☐No
Heart Disease	☐Yes ☐No	Latex/Metals/Jewelry Allergy	☐Yes ☐No
Congenital Heart Defect	☐Yes ☐No	Nervous Disorders	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Bisphosphonate Medication (Fosomax or Actonel)	☐Yes ☐No
Hemophilia	☐Yes ☐No	Diabetes	☐Yes ☐No
Hypertension/High Blood Pressure	☐Yes ☐No	Seizures/Epilepsy	☐Yes ☐No
Prolonged Bleeding/ Transfusion	☐Yes ☐No	Handicaps/Disabilities	☐Yes ☐No
Anemia	☐Yes ☐No	Asthma	☐Yes ☐No
HIV/AIDS	☐Yes ☐No	Arthritis	☐Yes ☐No
Tonsils/Adenoids Removed	☐Yes ☐No	Mental/Emotional Health Treatment	☐Yes ☐No
Hepatitis (A, B, C, or other)	☐Yes ☐No	Any Hospitalizations	☐Yes ☐No
Autism Spectrum Disorder	☐Yes ☐No		

If any of the above dental questions were answered "Yes", please explain:

List of any medications currently taken by the Patient: _____

List of any drug allergies or sensitivities that the Patient may have: _____

Patients Under the Age of 18

Height: _____ Weight: _____ School: _____Grade:_____

Father/Guardian 1 Name: _____Mother/Guardian 2 Name: _____

1. Has the Patient begun puberty? ☐Yes ☐No
2. Has the Patient grown in the past year? ☐Yes ☐No
3. Has shoe size changed recently? ☐Yes ☐No
4. Is the Patient interested in treatment? ☐Yes ☐No
5. If the patient is a girl, has menstruation begun? ☐Yes ☐No
6. If the patient is a boy, has his voice changed or has he grown facial hair? ☐Yes ☐No
7. Has either biological parent ever had Orthodontic Treatment? ☐Yes ☐No

I understand that the information provided is correct to the best of my knowledge. I understand that it is my responsibility to inform the office of any changes in the patient's health or medical status. I authorize the dental staff to perform the necessary dental services my child/patient may need during diagnosis and treatment with my informed consent. A panoramic x-ray and a cephalometric x-ray maybe taken to aid in the diagnosis of treatment. All x-rays taken by the practice are the property of the practice unless paid for by the parent/patient. I authorize the dental staff to perform the necessary dental services my child/patient may need during diagnosis and treatment with my informed consent. **Ortho_____

_____ _____ _____

PRINT PATIENT NAME **SIGNATURE OF PATIENT/PARENT/GUARDIAN** **DATE**

What's Important When Choosing Treatment?

Please rate what aspects of treatment are most important to you

	Not important	**Somewhat important**	**Important**	**Very important**	**Extremely important**
1. LENGTH OF TREATMENT	1	2	3	4	5
2. COMFORT DURING TREATMENT	1	2	3	4	5
3. TREATMENT USING LATEST TECHNOLOGY	1	2	3	4	5
4. CLEAR/INVISIBLE TREATMENT TECHNOLOGY	1	2	3	4	5
5. HAVING A LOW DOWN PAYMENT	1	2	3	4	5
6. HAVING A LOW MONTHLY PAYMENT	1	2	3	4	5
7. QUALITY OF TREATMENT	1	2	3	4	5
8. HOW INTERESTED ARE YOU IN STARTING ORTHODONTIC TREATMENT WITHIN THE NEXT MONTH?	1	2	3	4	5

PATIENT NAME: _____ ***DATE:*** _____

Please let us know about anything we may have missed that is important:

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14th, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: in addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect, Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Making Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, have received a copy of this office's Notice of Privacy Practices

Please Print Name of Patient:

_____

Please Print Name:

_____

Signature:

_____