Adult Patient Information

Patient Name (first, middle, last):_____Date:_____

Prefer to be called:_____Gender:_____D.O.B.:_____Age:_____

Address:_____

Contact Phone:_____Email for reminders:_____

May we leave a voice message? Y / N

Hobbies or Interests:_____

Employer:_____Occupation:_____

General Dentist:_____

Whom may we thank for referring you?_____

Responsible Party Information

Responsible Party Name:_____D.O.B.:_____

Relationship to Patient:_____Contact Phone/s:_____

May we leave a voice message? Y / N Email address:_____

Address if different from patient:_____

Employer:_____Occupation:_____

Insurance Carrier:_____Insurance Phone:_____

Social Security Number:_____Policy ID Number:_____

Responsible Party Name:_____D.O.B.:_____

Relationship to Patient:_____Contact Phone/s:_____

May we leave a voice message? Y / N Email address:_____

Address if different from patient:_____

Employer:_____Occupation:_____

Insurance Carrier:_____Insurance Phone:_____

Social Security Number:_____Policy ID Number:_____

Dental History

Patient Name:_____D.O.B.:_____Date:_____

Dentist:_____

Date of last cleaning (approximately)_____Any dental work needed?_____

Any teeth chipped or injured?_____

Any teeth for which endodontic treatment (root canal) was recommended or performed?_____

_____Any missing or supernumerary (extra) teeth?_____

Any teeth sensitive to hot, cold, or pressure?_____Clenching or grinding?_____

Are you aware of any issues with your temporomandibular joint ("TMJ")? Some symptoms may include popping, clicking, discomfort of the joint when opening or closing, soreness of the jaw muscles or around the ear._____

Any history of habits such as tongue thrusting or finger sucking?_____

Still present?_____Approx. time stopped_____

Have you ever been informed of any periodontal problems (involves gums and the supporting bone of teeth)?_____

Any history of unpleasant dental experiences?_____

Do you have dental anxiety?_____

Have you had any previous orthodontic treatment? Describe._____

_____

What are your primary orthodontic concerns?_____

Health History

Physician:_____Last seen (approx..)_____

<u>Allergies:</u>

Are you allergic to any medications:_____

Are you allergic to any foods:_____

Are you allergic to latex (present in some intraoral elastics that may be used in orthodontic treatment):_____

Are you allergic to any metals (some orthodontic wires contain small quantities of nickel)_____

Any other allergies (include seasonal):_____

Health History (cont'd)

Patient Name:_____D.O.B.:_____

Medications:

Please list any medications that have been taken in the last year:_____

_____

_____

Has the patient ever taken a class of medications called Bisphosphonates? (This would be rare in children). Oral examples are Actonel, Boniva, Fosamax, Skelid, and Didronel. Intravenous examples are Zometa and Aredia. Fosamax is a relatively weak version of this class of drugs. Some can have a significant and long term effect on bone metabolism which is an extremely important part of safe and effective orthodontic treatment._____

Medical History:

Do you currently or have you ever had a history of issues with any of the following (please check):

____Abnormal Bleeding	____Diabetes	____H.I.V.
____Asthma	____Ear, Nose, Throat Issues	____Kidney Problems
____Birth Defects/Heredity Problems	____Endocrine Problems	____Liver Problems
____Blood Disorders	____Fainting/Dizziness	____Mitral Valve Prolapse
____Bone Disorders	____Gastrointestinal Issues	____Seizures
____Cancer	____Hearing Impairment	____Speech Problems
____Cardiovascular Problems	____Heart Murmur	____Tuberculosis
____Congenital Heart Defects	____Hepatitis	____Vision Problems

History of any operations or hospitalizations?_____

_____

History of major injuries or car accidents?_____

_____

***Females-Is there any possibility that you are pregnant?_____

Have you ever been advised to be pre-medicated with antibiotics prior to dental procedures?_____

Please list any other health issues or concerns that have not been addressed:_____

_____

Completed by:_____Date:_____

WATERS
ORTHODONTICS
David A. Waters, D.M.D.

Consent for Email and Text Reminders

Our office sends appointment reminders by text and email. We will not use your contact information for marketing or advertising messages.

Patient's Name:_____

I authorize appointment reminders by:

□ Text _____

□ Email _____

□ I understand that appointment reminders are a courtesy and only sent by text and email.

Signature:_____Date:_____Printed Name:_____

Relationship:

□ Self □ Parent □ Guardian □ Other_____

Authorization & Consent to Send Patient Information by Email & Other Electronic Means

Until I tell you in writing to stop, I authorize Waters Orthodontics to transmit patient information relating to my treatment, health, or payment by email or other electronic means to me, someone I designate, health care providers, health plans, and others involved in my treatment. I understand that:

- Sensitive information such as X-rays and referral information will not be sent encrypted unless requested by me.
- Appointment reminders and credit card receipts will be sent without encryption.
- Information regarding payments, insurance, and treatment will be sent without encryption unless requested otherwise by me.
- I do not have to sign this form.
- If I don't sign this form, Waters Orthodontics may use other ways to send my information, such as U.S. mail, or ask me to deliver to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- **Waters Orthodontics does not email such sensitive personal information such as Social Security numbers, complete credit card numbers, insurance i.d. numbers, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists**.
- I can tell you in writing to stop emailing my patient information, but if I do so, this will not affect emails that Waters Orthodontics already sent before receiving my written instructions to stop.

□ I agree to the above □ I prefer that emails other than reminders be encrypted

Patient Name:_____Date:_____

Representative's Printed Name:_____Relationship:_____

Signature:_____