Patient ID:__________________

CONFIDENTIAL MEDICAL/DENTAL HISTORY
FOR PATIENTS OVER 18

North Office: 4935 Templeton Gap Road, Colorado Springs, CO 80923 Tel: 719-266-6224
South Office: 1539 South 8th Street, Ste. 200, Colorado Springs, CO 80905 Tel: 719- 227-7645
Email: info@smilesforcolorado.com www.smilesforcolorado.com

Patient's Last Name:____________________________ First Name:______________________ MI:_____

Prefers to be Called:_________________ Birth Date:_________ Age:_________ Sex: ☐ Male ☐ Female

Social Security Number:________________________________

Patient's Address:____

City:____________________________________ State:______________ Zip Code:_________________

Home Phone:________________ Cell/Other:________________ Email:___________________________

Employer/Occupation:___________________________________ Business Phone:___________________

☐ Single ☐ Widowed ☐ Divorced ☐ Married Spouse's Name:_________________________________
____

Employer/Occupation:__________________________________ Business Phone:___________________

Name of Dentist:_________________________________ Date of Last Dental Visit:________________

How did you hear about our office?____

Other Family Members treated at this office?____

PERSON RESPONSIBLE FOR ACCOUNT: ____

PRIMARY INSURANCE INFORMATION	**SECONDARY INSURANCE INFORMATION**
Policy Holder's Name:_______________________	Policy Holder's Name:_______________________
Date of Birth:______________________________	Date of Birth:______________________________
Social Sec. #______________________________	Social Sec. #______________________________
Relationship to Patient:_____________________	Relationship to Patient:_____________________
Employer:_________________________________	Employer:_________________________________
Work Phone:_______________________________	Work Phone:_______________________________
Insurance Company:_________________________	Insurance Company:_________________________
ID#_________________ Group#_____________	ID#_________________ Group#_____________
Address:__________________________________	Address:__________________________________
Phone # on Ins. Card:_______________________	Phone # on Ins. Card:_______________________

MEDICAL HISTORY

Your answers are for office records only, and are confidential. A thorough medical and dental history is essential to a complete orthodontic evaluation.

1. Have you ever had any of the following? Please check those that apply:

- □ HIV/AIDS
- □ Allergies__________________
- ___________________________
- ___________________________
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Blood Disease
- □ Brain Injury
- □ Bone Disorder
- □ Chest Pain, Shortness of Breath
- □ Chemotherapy
- □ Cancer
- □ Diabetes, or low blood sugar
- □ Dizziness
- □ Earaches
- □ Emotional Problems
- □ Epilepsy
- □ Excessive Bleeding
- □ Fainting/Dizziness
- □ Glaucoma
- □ Hay Fever
- □ Frequent Headaches or Migranes
- □ Head Injuries
- □ Heart Murmur
- □ Hepatitis, or liver problem
- □ High or Low Blood Pressure
- □ Jaundice
- □ Kidney Disease
- □ Liver Disease
- □ Mental Disorders
- □ Mitral Valve Prolapse
- □ Nervous Disorders
- □ Pacemaker
- □ **Pregnancy** Due Date:_____________
- □ Radiation Treatment
- □ Removal of Adenoids or Tonsils
- □ Respiratory Problems
- □ Rheumatic Fever
- □ Rheumatism
- □ Sinus Problems
- □ Speech Problems
- □ Stomach Problems
- □ Seizures, Neurologic Problems
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Tumors
- □ Ulcers
- □ Vision, hearing problems
- □ Venereal Disease
- □ Other:________________
- ______________________

2. Have you been admitted to a hospital or needed emergency care during the past two years? □Yes □No
   If yes, please explain ____
3. Have you ever taken Bisphosphonate medication (e.g. Fosamax, Actonel, Boniva, Skelid or Didronel for bone disorder)?
   □Yes □No If yes, what medication and length of time on the medication ______________________________________
4. Are you now under the care of a physician? □Yes □No
   Name of Physician:____Phone:________________________________
5. Do you currently have (or ever had) a substance abuse problem? □Yes □No
6. Do you chew or smoke tobacco? □Yes □No
7. List any medication, nutritional supplements, herbal medications or non-prescription medicines that you currently take:
   Medication _____________________________ Taken for _______________________________
   Medication _____________________________ Taken for _______________________________
   Medication _____________________________ Taken for _______________________________
8. Are there any medical conditions we have not listed and you feel we should be aware of? □Yes □No
   If yes, please explain ____

FOR
COLORADO ORTHODONTICS

DENTAL HISTORY

1. What concerns you most about your teeth?____
2. Do you have any current dental problems?____
3. Have you ever had orthodontic treatment? □Yes □No
   If yes, please explain:____
4. Has anyone in your family received orthodontic treatment? □Yes □No
   If yes, who?____
5. Do you feel nervous about having dental treatment? □Yes □No
   If yes, what is your biggest concern?____
6. Have you ever had an upsetting dental experience? □Yes □No
   If yes, please describe:____

Please answer the following:

- ♦ Are you presently in any dental pain? □Yes □No
- ♦ Are your teeth sensitive? □Yes □No
- ♦ Do your gums bleed or hurt? □Yes □No
- ♦ Permanent or extra (supernumerary) teeth removed? □Yes □No
- ♦ Have you noticed any loose teeth or changes in your bite? □Yes □No
- ♦ Have there been any injuries to the face, mouth or teeth? □Yes □No
- ♦ Bleeding gums, bad taste or mouth odor? □Yes □No
- ♦ Abnormal swallowing (tongue thrust)? □Yes □No
- ♦ Mouth breathing habit or snoring at night? □Yes □No
- ♦ Food impaction between teeth? □Yes □No
- ♦ History of speech problems or speech therapy? □Yes □No
- ♦ Do you clench or grind your teeth? □Yes □No
- ♦ Do you have a clicking or popping in your jaw? □Yes □No
- ♦ Do you have difficulty opening or closing your mouth? □Yes □No
- ♦ Have you ever been told you have a TMJ problem? □Yes □No
- ♦ Do you get frequent headaches? □Yes □No

I have read the above questions and understand them. To the best of my knowledge, all of the preceding answers and information are true and correct. I will not hold the orthodontist and any member of the staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the orthodontist of any changes in my medical and dental health.

____ Date:________________________
Signature of patient, parent, or guardian

MEDICAL HISTORY UPDATES

____ Date:________________________
Signature of patient, parent, or guardian

____ Date:________________________
Signature of patient, parent, or guardian

____ Date:________________________
Signature of patient, parent, or guardian

CONSENT FOR SERVICES

- I certify that the information provided is accurate and will be relied upon for granting credit and providing services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
- By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
- I authorize payment directly to the orthodontist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
- I hereby authorize the orthodontist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the orthodontist to make a thorough diagnosis.
- I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

____ Date:______________________
Signature of patient, parent, or guardian

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 TO US

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 physician or other healthcare provider providing treatment to you, or to family and friends you approve.
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 connections 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. You also have the right to request restriction on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.
Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.
Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. Requests of a patient's records must be made in writing and can take up to ten business days to process. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you are encouraged to make any complaints to us directly. You also may submit a written complaint to the U.S Department of Health and Human Services. We support your right to the privacy of your health information.

PATIENT ACKNOWLEDGEMENT OF REVIEWING AND UNDERSTANDING OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

I,____, consent to the use
(Print Patient or Parent or Legal Guardian Name)

and disclosure of the patient's personal health information by this office for treatment, billing/payment, and healthcare operations as outlined in the Notice of Privacy Practices.

____

Signature of Patient or Parent or Legal Guardian Name Date