Scott & Jane
ORTHODONTICS

ADULT PATIENT INFORMATION

Date______________________

Patient's name ____
Last First Middle

Address____
Street City Zip

Home phone _________________ Work phone ____________________ Cell/other phone _________________

Social Security # _________________ ______ Birthdate __________________ Email ______________________

Employer____ Occupation ______________________

Spouse's Name ____ Work Phone _____________________

Spouse's Social Security # __________________ ____________________ Spouse's Birthdate ________________

Spouse's Employer____ Occupation______________________

Whom may we thank for referring you to our office? ____

DENTAL INSURANCE INFORMATION

Subscriber's Name____ Member ID or SSN # ______________

Subscriber Date of Birth ____ Group No. _______________________

Insurance Company____ Phone No. ______________________

Insurance Co. Address ____

Do you have dual coverage? Yes______ No______

EMERGENCY INFORMATION

Name of nearest relative not living with you ____

Complete address ____
Street City Zip

Phone____ Relationship to Patient _________________

DENTAL HISTORY

Why are you seeking orthodontic treatment? (Please be as specific as possible) _____________________________

____

General Dentist ____ Date of last visit _______________

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Yes No Are you presently in any dental pain? ____________________
Yes No Have there been any injuries to face, mouth, or teeth? ____________________
Yes No Do you have any type of thumb or tongue habit? ____________________
Yes No Have you ever seen an orthodontist? If yes, who and when? ____________________
Yes No What is your attitude toward receiving orthodontic treatment? ____________________
Yes No Has anyone in your family received orthodontic treatment? ____________________
How did they feel about the result? ____________________
Yes No Are you aware of your jaw clicking or popping? ____________________
Yes No Have you ever been told that you grind your teeth? ____________________
Yes No Do you have "tension" headaches? ____________________
Yes No Are you aware that some appointments will be during work hours? ____________________

MEDICAL HISTORY

Physician ____________________ Date of Last Visit ____________________
Address ____________________ Phone ____________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ____________________
Yes No Are you allergic to any medication? ____________________
Yes No Do you have a history of a major illness? ____________________
Yes No Do you need to be premedicated for routine dental procedures? ____________________
Yes No Have you had any operations? ____________________
Yes No Have you seen a physician in the last 12 months? Why? ____________________
Yes No Female Patients Only: Are you pregnant? ____________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? ____________________
____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Scott Huang or Dr. Jane Lu to perform a complete orthodontic evaluation.

Signature: ____________________ Date: ____________________

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: ____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Manager
E-mail: info@scottandjane.com

Telephone: 832-539-6388
Address: 5418 Highway 6, Suite 215, Missouri City, TX 77459

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____ Date: ___________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT