KNAPP ORTHODONTICS

PATIENT INFORMATION

First Name:_____ Last Name:_____ Preferred Name:_____ Sex:___

Birth date:_____ Age:_____ Cell Phone:_____ Secondary Phone:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Social Security #_____

School (if student)_____ Grade:_____

Employed by/ Occupation:_____ Business Phone:_____

Name and age of siblings:_____

Related patients or friends that are or have ever been under our care:_____

How did you hear about our office? Please list all that apply:

☐ **DENTIST** ☐ **RELATIVE** ☐ **PATIENT** ☐ **INSURANCE** ☐ **INTERNET** ☐ **SOCIAL MEDIA** ☐ **OTHER:**_____

Person responsible for account:_____ Relationship to patient:_____

PARENT INFORMATION **Please complete if patient is a minor.**

Father's Name/Guardian:_____

Address:_____

City:_____ State:_____ Zip:_____

SS#:_____ DOB:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Employer:_____

Email:_____

PARENT INFORMATION **Please complete if patient is a minor.**

Mother's Name/Guardian:_____

Address:_____

City:_____ State:_____ Zip:_____

SS#:_____ DOB:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Employer:_____

Email:_____

If divorce is involved, who is the custodial parent? _____

May patient information be released to the non-custodial parent? ◯ **YES** ◯ **NO**

INSURANCE INFORMATION

Primary Insurance Company:_____ Phone Number_____

Insured's Name:_____ Insured's DOB_____ Insured's SSN:_____

ID Number:_____ Relationship to Patient:_____

Insured's Employer:_____ Group Number:_____

Secondary Insurance Company:_____ Phone Number_____

Insured's Name:_____ Insured's DOB_____ Insured's SSN:_____

ID Number:_____ Relationship to Patient:_____

Insured's Employer:_____ Group Number:_____

PATIENT DENTAL HISTORY

Name of Dentist:_____

What is your primary concern or your reason for visiting?_____

Date of last cleaning:_____

Do you have any cavities or dental work that needs to be completed? Y/N

Have you had orthodontic treatment previously? Y/N

Mouth breathing habit or snoring at night? Y/N

Tooth grinding or clenching? Y/N

Clicking, locking in jaw joints? Y/N

Have you ever had a "deep cleaning" or gum disease? Y/N

Do you have a date scheduled to complete it? Y/N/NA

Have you chipped or injured your permanent teeth? Y/N

Do you have any type of thumb or tongue habit? Y/N

Do you have sore jaw muscles or face muscles? Y/N

Difficulty chewing or opening jaw? Y/N

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PATIENT MEDICAL HISTORY:

Name of Physician:_____ Phone Number of Physician:_____

Address of Physician:_____Date of recent physical exam:_____

List any drugs/medications currently being taken:_____

Do you take antibiotic pre-medication before any dental procedure? ◯YES ◯ NO Reason if YES:_____

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

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

Infective endocarditis/valvular heart disease? ◯YES ◯ NO

Prosthetic cardiac valves or material, history of IE, cardiac transplant, unrepaired cyanotic congenital heart disease, repaired with shunts?◯ YES ◯ NO

Please check all that apply:

- ◯ Hereditary or developmental conditions
- ◯ Bone fractures or major injuries
- ◯ Any injury to the face, head or neck
- ◯ Excessive bleeding or bruising, or anemia
- ◯ Chest pain, shortness of breath, tire easily, swollen ankles
- ◯ Diabetes or low blood sugar
- ◯ Heart defects, heart murmur, rheumatic heart disease
- ◯ Tonsil or adenoid condition
- ◯ Seizures, fainting spells, or neurological problems
- ◯ Immune system problems
- ◯ History of osteoporosis
- ◯ Gonorrhea, syphilis, herpes, STD
- ◯ AIDS or HIV Positive
- ◯ Hepatitis, jaundice, or other liver problems
- ◯ Pollo, mononucleosis, tuberculosis, or pneumonia
- ◯ Stomach ulcer or acid reflux
- ◯ Mental health disturbance or depression
- ◯ Vision, hearing, or speech problem
- ◯ History of eating disorder (anorexia, bulimia)
- ◯ High or low blood pressure
- ◯ Arthritis or joint problems
- ◯ Endocrine or thyroid problems
- ◯ Kidney problems
- ◯ Angina, arteriosclerosis, stroke, or heart attack
- ◯ Prosthetic join replacement/implant (knee, hip)
- ◯ Frequent migraines or headaches
- ◯ Frequent ear infections, colds, or throat infections
- ◯ Asthma, sinus problems, hay fever
- ◯ Cancer, tumor, radiation treatment, or chemotherapy
- ◯ Skin disorder (other than common acne)

Are you **ALLERGIC** to or have you had any reactions to the following? Check all that apply:

◯ Latex Rubber ◯ Any Metals (nickel, mercury, etc.) ◯ Acrylics ◯ Local Anesthetics (Novocain, lidocaine)
◯ Penicillin or other antibiotics ◯ Other:_____

Are you pregnant? ◯YES ◯NO Are you trying to become pregnant? ◯YES ◯ NO
Do you chew tobacco? ◯YES ◯NO Do you smoke any substance or vape? ◯YES ◯ NO

AUTHORIZATION AND RELEASE

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release ofall medical records on the above-named patient to the referring dentist, physician or other health care provider, as well as information and records necessary for processing insurance claims. I authorize the release of financial information for collectionand records transfer purposes. I authorize the necessary diagnostic tests and any orthodontic treatment deemed necessary to be performed by or under the direction of Dr. Knapp and/or associates of Knapp Orthodontics. I give my permission for any photographs, x-rays or study models to be updated during treatment and to be used for displays in our office, on our website, at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I hereby authorize the necessary credit information to be obtained by Knapp Orthodontics or other third-party company for the purposes of consideration of payment options. We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic account. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

_____ _____ _____

Signature **Relationship to Patient** **Date**

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PRIVACY CONSENT- Please alert a staff member if you would like a copy of this form.

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form. Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure). You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent. You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice. You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent. Thank you for your cooperation. Please let us know if you have any questions.

Print Name _____ **Patient's Signature** _____ **Date** _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, emailaddresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more ofthe following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization,which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

You can now text or call us at (256) 532-8900. Just like phone calls and voicemails, texting may not always be 100% secure depending on the mobile service you use**. Your signature on this form serves as consent to receiving text messages from Knapp Orthodontics. Please alert us if you do not consent.**

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.