GARDNER ORTHODONTICS

Roberta Z. Gardner, DMD, MS
Diplomate, American Board of Orthodontics

WELCOME TO OUR OFFICE

Patient s Name_____ Birthdate_____ Age_____
Email Address_____ Home Phone #_____ Cell Phone #_____
Street Address_____ City_____ State___ Zip_____
General Dentist_____ Other family members seen by us _____
Who may we thank for referring you to our office?_____
School_____

RESPONSIBLE PARTY

Person Responsible for Account_____Relationship to patient_____
S.S.#_____ _____ _____ Does the responsible party have custody? Yes No
Responsible Party s Marital Status? Single Married Divorced Other _____
Employer _____Work Phone #_____
If the responsible party s information is different from above, please fill out the following:
Email address_____ Home Phone #_____ Cell Phone #_____
Street Address _____ City_____ State___ Zip_____

OTHER RESPONSIBLE PARTY

If there are two responsible parties, please fill out the following:
Second Responsible Party_____ Relationship to Patient_____
Email address_____ Home Phone # _____ Cell Phone # _____
Street Address _____ City_____ State____Zip_____
Employer _____ Work Phone # _____

INSURANCE INFORMATION

Insurance Company_____ Phone#_____
Policy Holder Name_____Birthdate _____
Policy or S.S.#_____
Employer_____

This office will gladly submit for the insurance benefits, however you are responsible for any co-payment, deductible and balance that the insurance does not cover.

PLEASE FILL OUT ALL THAT APPLY TO THE PATIENT

When was your last visit to your dentist?_____
Any injuries to face, mouth, chin, teeth? Yes No Tonsils and Adenoids removed? Yes No
Tenderness in jaw or joint? Yes No Previous orthodontic treatment? Yes No

PLEASE MARK ALL THAT APPLY TO PATIENT

_____ Clenching / Grinding Teeth _____ Lip Sucking / Biting _____ Mouth Breather _____ Nail Biting
_____ Nursing Bottle Habits _____ Speech Problems _____ Thumb / Finger Sucking _____ Tongue Thrust

MEDICAL HISTORY

PLEASE MARK ALL THAT APPLY TO PATIENT.

____ Abnormal Bleeding	____ Anemia / Radiation Treatment	____ Artificial Bones/Joints/Valves
____ Blood Transfusion	____ Cancer / Chemotherapy	____ Congenital Heart Defect
____ Diabetes / Tuberculosis (TB)	____ Difficulty Breathing	____ Drug / Alcohol Abuse
____ Emphysema / Glaucoma	____ Epilepsy / Seizures / Fainting	____ Fever Blisters / Herpes
____ Heart Attack / Stroke	____ Heart Murmur	____ Heart Surgery / Pacemaker
____ Hemophilia	____ Hepatitis	____ High / Low Blood Pressure
____ HIV + / AIDS	____ Hospitalized for any Reason	____ Kidney Problems
____ Mitral Valve Prolapse	____ Psychiatric Problems	____ Rheumatic / Scarlet Fever
____ Severe / Frequent headache	____ Shingles	____ Sinus Problems
____ Surgery	____ Ulcers / Colitis	

Please discuss any medical conditions: _____

Allergies: _____

Current Medications: _____

Has puberty begun? Yes No **Has menstruation begun? Yes No**

EMERGENCY INFORMATION

In case of emergency: _____ Phone # _____
Relationship to patient: _____
Physician: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and that is my responsibility to inform the office of any changes in my/patient s medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.
Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I UNDERSTAND THAT UNDER THE *Health Insurance Portability & Accountability Act* of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

_____OFFICE USE ONLY_____

I attempted to obtain the patient s signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____