Adult Patient Information

Patient's Name ____ Birthdate ____________________
Last First Middle

Address ____
Street City Zip

Years at above address?_________ SS#_______-_______-_______ E-Mail ______________________________

Home Phone____________________Cell Phone____________________ Work Phone __________________________

Employer_____________________________________ Occupation____________________ No. years employed _____

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

Spouse's Name ____ E-Mail ____________________
Last First Middle

Home Phone_____________________Cell Phone_____________________Work Phone________________________

Address ____
Street City Zip

Employer_____________________________________ Occupation____________________ No. years employed _____

Insurance Information

Primary

Dental Ins. ____ Phone __________________________

Name of Insured ____ Birthdate ___________________
Last First Middle

ID#_____________________________ Group Name___________________________Group # ____________________

Secondary

Dental Ins. ____ Phone __________________________

Name of Insured ____ Birthdate ___________________
Last First Middle

ID#_____________________________ Group Name___________________________Group # ____________________

Emergency Information

Name of nearest relative not living with you ____

Complete address ____
Street City Zip

Phone ____

Patient Signature ____

MEDICAL HISTORY

Patient Name ________________________
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 Have you had any major operations? ____
Yes No Have you ever been involved in a serious accident? _____________________________

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

Abnormal bleeding/Hemophilia	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? ________________________
____

Yes No Are you allergic to latex?

DENTAL HISTORY

Dentist_____________________________________ Date of Last Dental Cleaning and Checkup ____________________
What concerns you most about your teeth? ____

Yes No Are you presently in any dental pain? ____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _______________________
Yes No Have you ever lost or chipped any teeth? ____
Yes No Have there been any injuries to face, mouth or teeth? ______________________________
Yes No Is any part of your mouth sensitive to temperature or pressure? _________________________
Yes No Do your gums bleed when you brush? ____
Yes No Do you have any type of thumb or tongue habit? ____________________________________
Yes No Are you a mouth breather? ____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____________________________
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 Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ___________________
Yes No Are you aware of your jaw clicking or popping? _____________________________________
Yes No Are you aware of clenching your teeth during the day? _______________________________
Yes No Have you ever been told that you grind your teeth? _________________________________
Yes No Do you have "tension" headaches? ____
Yes No Have you ever experienced chronic ringing in your ears? _____________________________
Yes No If the patient is under age 16, height of parents? Mom______ Dad______
Yes No Are you aware that some appointments will be during school/work hours? ___________________
Please list some hobbies or interests ____
Female Patients only:
Yes No Are you pregnant? ____
Yes No Has menstruation started? ____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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. Housley and/or Dr. Dobson to perform a complete orthodontic evaluation.

Signature: ____ Date: ____________________

JEFFREY A. HOUSLEY, DDS, MS

BRENT S. DOBSON, DDS, MS

YOUR SMILE IS OUR SPECIALTY

BOARD CERTIFIED ORTHODONTISTS

PATIENT REQUEST FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION & CONSENT FOR CELL PHONE CONTACT

I, the undersigned, hereby request that Owasso Orthodontics communicate about all Protected Health Information (PHI) by conventional, unencrypted email. This PHI includes, but is not limited to: potential treatment plans, fees associated with treatment, insurance information, birthday well wishes, appointment dates/times and treatment progress.

I understand that this increases the risk that the PHI could be read or accessed by a third party while in transit. If my PHI is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this request at any time by delivering a revocation in writing to Owasso Orthodontics. After that point, email communication with me about all PHI will be protected by password encryption. If I revoke this request, it will have no effect on actions already taken by Owasso Orthodontics in reliance on this request.

I authorize the request described herein. I have read and understand this request. I am the patient listed on this request or am authorized to act on behalf of the patient as the patient's personal representative.

☐ I consent to Owasso Orthodontics using my cell phone to call and/or text regarding appointments, insurance and my account. I also consent to using my cell phone to call and/or text as needed regarding treatment progress or for resolution of minor orthodontic emergencies. This may require the texting of photos taken by parent or patient. I understand that I can withdrawal my consent at any time.

My cell phone number is: ____

Printed Name of Patient: ____

Printed Name of Legal Guardian: ____

Signature of Patient or Legal Guardian: ____

Date: ____

Witness: ____

E-mail: ____

12813 East 101st Place North Owasso, OK 74055 (918) 272-4242 (918) 272-5753 Fax

www.OwassoOrthodontics.com

JEFFREY A. HOUSLEY, DDS, MS BRENT S. DOBSON, DDS, MS

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BOARD CERTIFIED ORTHODONTISTS

Assignment of Benefits and Authorization Release

I hereby authorize and request my insurance company to assign benefits directly to my orthodontist. If my current policy prohibits direct payment to my orthodontist, I hereby agree to pay the orthodontist the sum equal to the insurance payment received by me. I shall mail the check as follows:

Payable to: Owasso Orthodontics
Mail to: Owasso Orthodontics
12813 E. 101st Place North
Owasso, OK 74055

I authorize the treatment provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, and for any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this Assignment shall be considered as effective and valid as the original.

__________________________________ ____________________
Signature of Subscriber Date

Subscriber Name: ______________________________

Patient Name:

Subscriber D.O.B.: ______________________________

Subscriber SSN or Member ID: ______________________

Employer: __________________________________

Insurance Company: _____________________________

Insurance Phone: ______________________________

Email to: info@owassoorthodontics.com
Fax to: 918-272-5753

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