

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

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 number to call and/ or text regarding appointments, insurance, and my account. 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: _____



JEFFREY A. HOUSLEY, DDS, MS

BRENT S. DOBSON, DDS, MS

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: _____

Subscriber D.O.B.: _____

Subscriber SSN or Member ID: _____

Employer: _____

Insurance Company: _____

Insurance Phone: _____

Email to: info@owassoorthodontics.com

Fax to: 918-272-5753