

### NEW PATIENT - ADULT

Have you been seen at any of our other locations?  Yes  No If yes, where: \_\_\_\_\_

How did you learn about our practice? Whom can we thank for referring you to us? \_\_\_\_\_

What is your main concern? What would you like to change about your smile?  
\_\_\_\_\_

Have other family members been treated here?  Yes  No If yes, list names: \_\_\_\_\_

### PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Title: \_\_\_\_\_

Preferred Name/Nickname: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt/Unit#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnic Origin: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

In case of emergency, call: \_\_\_\_\_ Phone: \_\_\_\_\_

### DENTAL HISTORY

Dentist's Name: \_\_\_\_\_

Date of last cleaning/exam: \_\_\_\_\_ Is any dental work needed?  Yes  No

Have you ever had an orthodontic consultation?  Yes  No

Have you had any injuries to the face, mouth, or teeth?  Yes  No

Do you have any pain/tenderness in the jaw joints (TMJ/TMD)?  Yes  No

Have you been diagnosed with periodontal disease/bone loss?  Yes  No

Do you have any of the following habits?  Thumb sucking  Tongue thrust  Grinding  Clenching

### MEDICAL HISTORY

Please check the box if you have or have had:

Positive HIV test

Tuberculosis

Tonsillitis

Joint swelling

Anemia

Adenoids removed

Bone disorders

Asthma

Brain injury

Heart trouble

Epilepsy

Emotional problems

Rheumatic fever

Prolonged bleeding

Kidney/liver issues

Thyroid problems

Faintness/dizziness

Ear aches

Diabetes

Tonsils removed

Hepatitis

## MEDICAL HISTORY (continued)

Do you have any medical alert conditions or allergies? \_\_\_\_\_

Do you have any medical concerns? \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Please list any medications that you are currently taking:

\_\_\_\_\_

Females Only: Are you pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_

Are there any behavioral or emotional conditions we should be aware of?

ADHD/ADD  Autism Spectrum Disorder  Anxiety Disorder  Sensory Disorder  Other: \_\_\_\_\_

## INSURANCE INFORMATION

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber Social Security Number/ID Number: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

## AUTHORIZATIONS

**Insurance Authorization:** I authorize my insurance company to pay directly to Prettyman Orthodontics and their associate dentists my insurance benefits that would otherwise be payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I have received, read, understand, and accept the Insurance and Financial Policy of Prettyman Orthodontics. In addition, by signing below I agree to receive calls from Prettyman Orthodontics staff at work, home, or by mobile phone to discuss matters related to my dental treatment, insurance, and financial arrangements.

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

**Authorization for Treatment:** I consent to the procedure decided upon to be necessary or advisable in the opinion of the Orthodontist.

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date



## PRACTICE POLICIES

- We require 24 hour prior notice if you are unable to keep your scheduled appointment. We reserve the right to charge you a cancellation fee and/or dismiss you from the practice if you fail to comply with this policy.
- When we call to confirm our appointments, we ask our patients to confirm their appointment by return phone call, email or text message within 24 hours after receiving your confirmation notification. Failure to comply with this policy will mean you scheduled as an "unconfirmed stand-by" patient and you may or may not be seen if you show for your appointment.
- There is a \$30.00 fee for transfer or release of patient's records, including x-rays.
- **Children may not be left alone** in the reception area and may not accompany you to the treatment rooms/ area. Please arrange for child care prior to your appointment or we reserve the right to reschedule your appointment.
- **Only patients** are allowed in the treatment rooms/area. If the patient is a minor, the parent or legal guardian will be allowed to accompany the patient to the treatment room where the treating doctor will explain the diagnosis, planned treatment and risks and benefits of the treatment. When it comes time to deliver the treatment to the patient, it will be at the discretion of the treating dentist whether they will allow the parent/ legal guardian to remain in the treatment room for the remainder of the appointment.
- Parent, legal guardian or nursing home staff must remain at the office during treatment if the patient is younger than 18 or is a resident or in the care of a group home, assisted living facility, nursing home or any other type of guardian care.
- Cell phone use is **NOT** permitted in the reception area or operatories. Please step outside of the building to use your cell phone.
- Food and beverage is not permitted in the reception area or operatories.
- Smoking is not permitted inside or within fifty (50) feet of the patient entrance.
- Weapons of any type (guns, knives, batons, etc), concealed or unconcealed, are not permitted inside.
- Please be considerate of others when talking. Patients who talk loudly or use inappropriate language may be asked to leave.

**I understand and agree to conform to the above practice policies.**

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Legal Guardian Signature: \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

We understand that your medical and dental information is personal and we are committed to protecting it. We create a record of the care and services at our office. We need this record to provide you with quality dental care and to comply with certain legal requirements. This notice will tell you about the way we may use and share your Protected Health Information (PHI).

**Patient Rights:** You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, the records will be sent as directed in a timely manner.

**We have a legal duty to:**

1. Keep your personal health information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current notice.
4. Notify you of an accidental disclosure of your private health information in a timely manner.

**We have the right to:**

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

**Notice of change to privacy practices:**

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

## USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following describes different ways that we use and disclose your medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose dental/medical information. We will not use or disclose your dental/medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. **For treatment:** We may use your PHI to provide you with dental treatment or services. We may disclose dental/medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
2. **For payment:** We may use and disclose your PHI for payment purposes. A bill may be sent to you or a third-party payer or collection agency. The information on or accompanying the bill may include dental/medical information.
3. **For health care operations:** We may use and disclose your PHI for our health care operations including quality assessments, evaluating the performance of employees and conducting training.
4. Prettyman Orthodontics may not sell or use your PHI for marketing or fundraising purposes without your signed authorization.
5. If you pay for your dental treatment and request that we disclose the procedure to your insurance company, we must comply with your request as long as you pay in full for the procedure in a timely manner.

**I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that by signing this 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.**

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Legal Guardian Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_