New Braunfels Orthodontic Associates FoundMySmile.com

Larry L. Layfield, D.D.S. *We're Gonna Be Your Smile's Best Friend.*

American Association of Orthodontists

MEDICAL DENTAL HISTORY FORM FOR ADULTS

CONFIDENTIAL

Date: _____

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: ____ Sex: Male Female I Prefer To Be Called: _____

S.S.N./S.I.N.: _____ E-mail address: _____

Home Phone No.: (____) ____ - ____ Cell phone number: (____) ____ - ____

Patient's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Years at this address: ____

If less than five years, previous address: _____ City: _____ State: ____ Zip: ____

Occupation: _____ Employer: _____ Years with Employer: ____

Business Phone No.: (____) ____ - ____

Patient is: Single Married Widowed Separated Divorced

Name Of Spouse/Closest Relative: _____ Phone No.: (if different than yours) (____) ____ - ____

Relationship To You: _____

Address (if different than yours): _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Name Of Patient's Dentist: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Name Of Patient's Physician(s): _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Who may we thank for referring you to our office? _____

Who Is Financially Responsible For This Account? ☐ Patient ☐ Other (complete below *ONLY* if ☒Other)

Last Name: _____ First Name: _____ Middle Name/Initial: _____

Address: _____ Phone No.: (____) ____ - ____

City: _____ State/Province: _____ Zip/Postal Code: _____

Insurance Coverage For Dental Treatment? Yes No Insurance Coverage For Orthodontic Treatment? Yes No

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employer: _____

Dental Insurance Company: _____ Group No. _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employer: _____

Dental Insurance Company: _____ Group No. _____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Now or in the past, have you had:

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
yes no dk/u Mental health disturbance or depression?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/ u Tired easily?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
yes no dk/u Skin disorder?
yes no dk/u Do you have a well-balanced diet?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Eye, ear, nose or throat condition?
yes no dk/u Asthma?
yes no dk/u Hayfever, sinus trouble or hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Osteoporosis?

Allergies or reactions to any of the following:

yes no dk/u Local anesthetics (Novocaine or Lidocaine)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin or other antibiotics
yes no dk/u Sulfa drugs
yes no dk/u Codeine or other narcotics
yes no dk/u Metals (jewelry, clothing snaps)
yes no dk/u Latex (gloves, balloons)
yes no dk/u Vinyl
yes no dk/u Acrylic
yes no dk/u Animals

yes no dk/u Foods (specify) _____
yes no dk/u Other substances (specify) _____
yes no dk/u Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

yes no dk/u Do you currently have or ever had a substance abuse problem?
yes no dk/u Do you chew or smoke tobacco?
yes no dk/u Operations? Describe: _____
yes no dk/u Hospitalized? For: _____
yes no dk/u Other physical problems or symptoms? Describe:
_____
yes no dk/ u Being treated by another health care professional?
For: _____
Date of most recent physical exam? _____
Do you have any other medical conditions that we should know about?
_____

WOMEN ONLY

yes no dk/u Are you pregnant?
yes no dk/u Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain.

Bleeding disorders_____
Diabetes_____
Arthritis_____
Severe allergies_____
Unusual dental problems_____
Jaw size imbalance_____
Any other family medical conditions that we should know about? _____

DENTAL HISTORY

Now or in the past, has the patient had:

yes no dk/u Permanent or "extra" (supernumerary) teeth removed?

yes no dk/u Supernumerary (extra) or congenitally missing teeth?

yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?

yes no dk/u Jaw fractures, cysts or mouth infections?

yes no dk/u "Dead teeth" or root canals treated?

yes no dk/u Bleeding gums, bad taste or mouth odor?

yes no dk/u Periodontal "gum problems"?

yes no dk/u Food impaction between teeth?

yes no dk/u "Gum boils", frequent canker sores or cold sores?

yes no dk/u Thumb, finger, or sucking habit? Until what age _____?

yes no dk/u Abnormal swallowing habit (tongue thrusting)?

yes no dk/u History of speech problems?

yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?

yes no dk/u Tooth grinding or jaw clenching?

yes no dk/u Any pain, clicking or locking in jaw or ringing in the ears?

yes no dk/u Any pain or soreness in the muscles of the face or around the ears?

yes no dk/u Difficulty in chewing or jaw opening?

yes no dk/u Have you ever been treated for "TMD" or "TMJ" problems?

yes no dk/u Aware of loose, broken or missing restorations (fillings)?

yes no dk/u Any teeth irritating cheek, lip, tongue or palate?

yes no dk/u Concerned about spaced, crooked or protruding teeth?

yes no dk/u Aware or concerned about under or over developed jaw?

yes no dk/u Any relative with similar tooth or jaw relationships?

yes no dk/u Any wisdom tooth problems?

yes no dk/u Had periodontal (gum) treatment?

yes no dk/u Had any serious trouble associated with any previous dental treatment?

yes no dk/u Been under another dentist's care?
Specialist _____
Other _____

yes no dk/u Ever had a prior orthodontic examination or treatment?

yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ floss: _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed:

_____

Date Signed: _____
(Patient)

New Braunfels Orthodontic Associates
Privacy Notice

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, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the 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 payer 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;

~OVER~

* 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 you 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.

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 you questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____

Patient Date
(Parent/Legal Guardian if patient is a minor)