MANZELLA ORTHODONTICS

# PATIENT FORMS

## Patient Information

| | | | |
|---|---|---|---|
| Your Legal Name: | | Preferred Name: | |
| DOB: | Gender: | Phone: | |
| Interests: | | | |
| Referred By: | | | |
| Past/present Family In Treatment At Our Office? | | | |
| Email: | | Marital Status/spouse's Name: | |
| Address: | City: | State: | Zip Code: |
| Employer: | | Occupation: | |

## Dental Insurance Information

| | | | |
|---|---|---|---|
| Insured's Name: | | Insured's Birthdate: | |
| Insured's Employer: | | Ssn: | |
| Insurance Company: | Group Number: | Subscriber/Employee Id #: | |
| Insurance Address: | City: | State: | Zip Code: |
| Phone Number: | | Do You Have Dual Coverage? ○ Yes ○ No | |

## Medical Information/History

| | |
|---|---|
| Dentist: | Last Cleaning: |
| Physician Name: | Last Exam: |

Please Check All That Apply:

- ○ Water is Fluorinated
- ○ Flosses Daily
- ○ Takes Fluoride Supplement
- ○ Brushes at Least Twice Daily
- ○ Gums Bleed
- ○ N/A

Please Indicate if You Have: (Check All That Apply)

- ○ Been Evaluated for Ortho Treatment Before
- ○ Undergone Orthodontic Treatment with Braces or Aligners
- ○ Ever Received an Injury to the Face, Mouth, Teeth, or Chin
- ○ Had Adenoids/Tonsils Removed
- ○ Been Informed about Missing or Extra Permenant Teeth
- ○ Been Told to take Antibiotics Prior to Dental Visits
- ○ Had Problems with Previous Dental Work
- ○ N/A

Currently Taking Or Ever Taken A Bisphosphonate? Includes Any Medication Used To Make Bones Stronger, Such As:

- ○ Boniva
- ○ Actonel
- ○ Fosamar
- ○ N/A
- ○ Other

## Medical Information/History

Please Check Any Habits You Have:

- ○ Clenching/Grinding Teeth
- ○ Mouth Breathing
- ○ Nursing/Bottle Habit
- ○ Thumb/Finger Sucking
- ○ Tongue Thrust
- ○ Excessive Snoring
- ○ Lip Sucking/Biting
- ○ Nail Biting
- ○ Speech Problem/Speech Therapy
- ○ Tobacco Use
- ○ Used Pacifier
- ○ N/A

List Medications Currently Taking And Reason:

Any Allergies or Reactions to Any of the Following:

- ○ Aspirin, Tylenol, Ibuprofen
- ○ Codeine or Other Narcotics
- ○ Local Anesthetics
- ○ Penicillin or Other Antibiotics
- ○ Sedatives
- ○ Sulfa Drugs
- ○ Other
- ○ Barbiturates
- ○ Latex
- ○ Metals
- ○ Plastic or Vinyl
- ○ Sleeping Pills
- ○ N/A

Please List any Serious Medical Problems You Have Experienced:

Now Or In The Past Have You Had:

- ○ Abnormal Bleeding
- ○ Endorcrine/Growth Disorder
- ○ Liver Problems
- ○ Skin Rash
- ○ Anemia
- ○ Cancer
- ○ Lupus
- ○ Artifical Bones/Joints
- ○ Heart Murmur
- ○ Measles
- ○ Kidney Problems
- ○ Chronic Sinus Problems
- ○ Hospital Stays
- ○ Mononucleosis
- ○ Chicken Pox
- ○ Hepatitis
- ○ Handicaps/Disabilities
- ○ Tuberculosis
- ○ Epilepsy
- ○ HIV/AIDS
- ○ Hemophilia/Blood Disorder
- ○ Hearing Impairment
- ○ Hives
- ○ Diabetes
- ○ Asthma
- ○ Congenital Heart Defect
- ○ Mitral Valve Prolapse
- ○ Trouble Sleeping/Sleep Apnea
- ○ None

## Emergency Information

Emergency Contact: Relationship: Phone:

SECTION B: TO THE PATIENT - PLEASE READ THESE STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

COMMUNICATION: Manzella Orthodontics reserves the right to communicate with the responsible party via text/e-mail regarding patient's treatment and finances. It is your responsibility to let us know if you would like to opt out of this feature.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request with this consent. We encourage you to read it carefully and completely before signing this consent.

OFFICE PROCEDURES: As a part of your complimentary consultation our office will take x-rays and photographs of your teeth. This is for diagnostic purposes and will not be billed to you or your insurance company. It is near impossible for our doctors to give accurate treatment plans without these records.

USE OF RECORDS: Manzella Orthodontics has the right to use patient photographs, x-rays, videos, and other photographic reproduction for the purpose of communication with your current and future dental and medical professionals. Our doctors also reserve the right for records obtained in our office to be used for professional, academic, patient education, and practice promotion. This includes, but is not limited to use on the Manzella Orthodontics website, brochures, and social media sites.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will make available upon request a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our notice, at any time by contacting our office.

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice or your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: _____ Date: _____