HESTER & MORRIS
ORTHODONTICS
Live Life Smiling

NAME PATIENT WANTS TO BE CALLED _____

NAMES OF OTHER FAMILY MEMBERS WE TREATED _____

NAMES AND AGES OF OTHER CHILDREN IN THE FAMILY _____

PATIENT INFORMATION

GENDER – M / F

PATIENT'S NAME _____ DATE _____
Last First Middle

ADDRESS _____
Street City State Zip

HOME PHONE _____ BIRTH DATE _____ AGE _____ PATIENT'S SCHOOL _____

E-MAIL ADDRESS FOR APPOINTMENT REMINDERS _____

IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME _____

HOW DID YOU HEAR ABOUT US? CIRCLE ALL THAT APPLY.

Family Dentist Friends/Family Radio School or Sports Team The Ortho Taxi or T-shirts Chamber of Commerce or Greeting Service

Our Website or Google, Yahoo, Etc Facebook/Twitter/Instagram Magazine/Newspaper Ad Phone Book

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

RESPONSIBLE PARTY INFORMATION

(PLEASE COMPLETE ENTIRE FORM)

NAME _____
Last First Middle

RESIDENCE _____
Street City State Zip

MAILING ADDRESS _____
Street City State Zip

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PREVIOUS ADDRESS (IF LESS THAN 3 YRS.) _____
Street City State Zip

SOCIAL SECURITY # _____ BIRTH DATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ # YRS. EMPLOYED _____

SPOUSE'S NAME _____ RELATIONSHIP TO PATIENT _____
Last First Middle

EMPLOYER _____ OCCUPATION _____ # YRS. EMPLOYED _____

SOCIAL SECURITY # _____ BIRTH DATE _____ WORK PHONE _____ CELL PHONE _____

– OVER –

DENTAL HISTORY

	YES	NO
PATIENT'S DENTIST _____ LAST SEEN _____		
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____	☐	☐
HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? _____ UNTIL WHAT AGE? _____	☐	☐
DOES THE PATIENT HAVE ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS? _____	☐	☐
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____	☐	☐
HAS THE PATIENT HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? _____	☐	☐
HAS THE PATIENT HAD ANY ORTHODONTIC TREATMENT? _____	☐	☐
IF SO, WHAT AGE? _____	☐	☐
DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH? _____	☐	☐
IS THE PATIENT ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS? _____	☐	☐
DOES THE PATIENT HAVE ANY CONGENITAL ABNORMALITIES? _____	☐	☐
LIST SPORTS AND INTEREST _____	☐	☐

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
DIABETES	☐	☐	TUBERCULOSIS	☐	☐	ENDOCRINE OR THYROID	☐	☐
PNEUMONIA	☐	☐	ANEMIA	☐	☐	PROLONGED BLEEDING	☐	☐
HEART TROUBLE	☐	☐	EPILEPSY	☐	☐	LIVER INVOLVEMENT	☐	☐
RHEUMATIC FEVER	☐	☐	ASTHMA	☐	☐	FAINTING OR DIZZINESS	☐	☐
BONE DISORDERS	☐	☐	KIDNEY INVOLVEMENT	☐	☐	NERVOUS DISORDERS	☐	☐

	YES	NO
HAVE YOU EVER BEEN TREATED FOR CANCER? _____	☐	☐
IS THE PATIENT IN GOOD HEALTH? _____	☐	☐
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASON. _____		
_____		
DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____	☐	☐
LIST ANY ALLERGIES OR DRUG SENSITIVITY _____	☐	☐
HAVE TONSILS AND ADENOIDS BEEN REMOVED? _____ WHAT AGE? _____		
GROWTH IN THE PAST 6 MONTHS _____ HAS PATIENT REACHED PUBERTY? _____	☐	☐
HEIGHT: PATIENT'S _____ MOTHER'S _____ FATHER'S _____	☐	☐
PATIENT'S PHYSICIAN _____ LAST SEEN _____	☐	☐
HAVE YOU TAKEN ANY MEDICATIONS FOR OSTEOPOROSIS IN THE PAST 3 YEARS? _____	☐	☐
IF SO, CIRCLE – FOSAMAX ACTONEL MIACALCIN BONIVA OTHER _____		

INSURANCE INFORMATION

INSURED'S NAME _____ INSURED'S SOC. SEC. # _____

INSURANCE COMPANY _____ GROUP # _____ LOCAL # _____

INSURANCE CO. ADDRESS _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

COMPLETE ADDRESS _____ PHONE _____

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE (PARENT'S SIGNATURE IF MINOR) _____

UPDATES (DATE & INITIAL) _____

Colson Printing Company 49083

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HIPAA Patient Consent Form

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is used to obtain authorization to release Protected Health Information regarding the following patient(s):

Patient Name: _____

Patient Name: _____

Patient Name: _____

I understand that I, or my child, have/ has certain rights to privacy regarding my/ his/ her protected health information. These rights are given to me/ him/ her under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize Hester & Morris Orthodontics and its employees to use and disclose my protected health information to carry out:

1. Treatment (including treatment by other healthcare providers involved in my treatment).
2. Payment collection from third party payers (i.e. insurance companies).
3. The day to day healthcare operations of the practice.
4. Educational and demonstrational activities.

I understand that Hester & Morris Orthodontics reserves the right to change the terms of this notice from time to time and that I may contact Hester & Morris Orthodontics at any time to obtain a more current copy of this notice. I understand that I have the right to request restrictions on how my or my child's protected health information is used and disclosed to carry out treatment, payment, health care operations, and educational and demonstrational activities.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize Hester & Morris Orthodontics to disclose my/ my child's Protected Health Information to the following people:

_____ _____ _____

_____ _____ _____

Responsible Party Name (Print) Responsible Party Signature Date

HESTER & MORRIS
ORTHODONTICS
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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____