TRUE IMAGE
ORTHODONTICS

*Experience a New Image*

# HIPAA Release Form

For More Information or to Report a Problem

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with us, contact our Privacy Officer by phone or mail as follows: **Dr. David Chen**. To file a complaint with the Secretary of HHS, send your complaint to: **Office for Civil Rights 1301 Young Street, Suite 1169 Dallas, Texas 75202.**

If you have any questions or want more information about this Notice of Privacy Practices, please contact our Privacy Officer.

I acknowledge that I received a copy of **True Image Orthodontic's** Notice of Privacy Practices.

Acknowledged By:_____ Date: _____

(Signature of Patient or Personal Representative)

## PATIENT HEALTH INFORMATION

**List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.**

**Medication Taken for**

**Medication Taken for**

**Medication Taken for**

**Have you ever taken any medications to strengthen your bones? Please describe.**

**Do you take antibiotic pre-medication before any dental procedures? Yes No**

**Do you or have you ever had a substance abuse problem?**

**Do you chew or smoke tobacco?**

**Have you noticed any changes in your face or jaws?**

**Any other physical problems?**

**How often do you brush?**

**How often do you floss?___**

**Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No**

## FAMILY MEDICAL HISTORY

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

**Bleeding disorders**

**Diabetes**

**Arthritis**

**Severe allergies**

**Unusual dental problems**

**Jaw size imbalance**

**Other family medical conditions?**

## RELEASE AND WAIVER

**I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.**

**Signature** _____

**Date**_____

**I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.**

**Signature** _____

**Date**_____

## MEDICAL HISTORY UPDATES OR CHANGES

**Changes**

**Patient Signature** _____

**Date**_____

## MEDICAL HISTORY

## PATIENT NAME:

**Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. *For the following questions mark yes, no, or don't know/understand (dk/u).***

**Now or in the past, has the *patient* had:**

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, or major injuries?
yes no dk/u Any injuries to face, head, neck?
yes no dk/u Arthritis or joint problems?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Diabetes or low sugar?
yes no dk/u Kidney problems?
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
yes no dk/u Stomach ulcer, hyperacidity, acid reflux?
yes no dk/u Immune system problems?
yes no dk/u History of osteoporosis?
yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or other liver problem?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Seizures, fainting spells, neurologic problem?
yes no dk/u Mental health disturbance or depression?
yes no dk/u Vision, hearing, or speech problems?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u High or low blood pressure?
yes no dk/u Excessive bleeding or bruising, anemia?
yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
yes no dk/u Skin disorder (other than common acne)?
yes no dk/u Do you eat a well-balanced diet?
yes no dk/u Frequent headaches or migraines?
yes no dk/u Frequent ear infections, colds, throat infections?
yes no dk/u Asthma, sinus problems, hayfever?
yes no dk/u Tonsil r adenoid condition?
yes no dk/u Do you frequently breathe through your mouth?

**Have you had allergies or reactions to any of the following:**

yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
yes no dk/u Latex (gloves, balloons)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin
yes no dk/u Other antibiotics
yes no dk/u Metals (jewelry, clothing snaps)
yes no dk/u Acrylics
yes no dk/u Plant pollens
yes no dk/u Animals
yes no dk/u Foods
yes no dk/u Other substances

## DENTAL HISTORY

**Now or in the past, have you 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 injured primary or permanent teeth?
yes no dk/u Any sensitive or sore teeth?
yes no dk/u Bleeding gums, bad taste or mouth odor?
yes no dk/u Jaw fractures, cysts, infections?
yes no dk/u Any teeth treated with root canals or pulpotomies?
yes no dk/u "Gum boils," frequent canker sores or cold sores?
yes no dk/u History of speech problems or speech therapy?
yes no dk/u Difficulty breathing through nose?
yes no dk/u Food impaction between the teeth?
yes no dk/u Mouth breathing habit or snoring at night?
yes no dk/u History of speech problems?
yes no dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
yes no dk/u Teeth causing irritation to lip, cheek or gums?
yes no dk/u Abnormal swallowing (tongue thrust)?
yes no dk/u Tooth grinding or clenching?
yes no dk/ u Clicking, locking in jaw joints?
yes no dk/u Soreness in jaw muscles or face muscles?
yes no dk/u Ringing in ears, difficulty in chewing or opening jaw?
yes no dk/u Have you ever been treated for "TMJ" or "TMD" problems?
yes no dk/u Any broken or missing fillings?
yes no dk/u Any serious trouble associate with previous dental treatment?
yes no dk/ u Have you ever been diagnosed with gum disease or pyorrhea?
yes no dk/u Have you ever had an orthodontic consultation or treatment before now?

General Dentist _____ Last Visit _____

How did you hear about our Practice? ❑Ad ❑Internet ❑ Family or Friend ❑Physician ❑Other

Name of person referring (if applicable) _____

What are the main concerns you would like orthodontics to accomplish?

_____

Have you visited an orthodontist before? ❑Y ❑N

When? _____ Reason? _____

Have your tonsils or adenoids been removed? ❑Y ❑N

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD) ? ❑Y ❑N

Do you have any missing or extra permanent teeth? ❑Y ❑N

Have you ever had an injury to (*select all that apply*) : ❑Teeth ❑Mouth ❑Chin

Do you have speech problems? ❑Y ❑N If so, explain _____

Do your gums bleed? ❑Y ❑N Do you smoke? ❑Y ❑N Do you like your smile? ❑Y ❑N

Do you currently or have you ever had any of the following habits (*check all that apply*)?

❑Clenching/Grinding Teeth ❑Nail biting

❑Lip Sucking/Biting ❑Thumb/ Finger Sucking

❑Mouth Breathing ❑Chewing/Eating Problems

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Are you currently being treated by a physician? ❑Y ❑N

Physician _____ Last Visit _____ Phone _____

Reason _____

Do you have any allergies/sensitivities to medications or latex? ❑Y ❑N If yes, please list allergies.

_____

Are you currently taking any prescription or over-the-counter medications? ❑Y ❑N

Please list, with dosage. _____

Are you pregnant or nursing? ❑Y ❑N ❑N/A

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- I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.
- I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- I understand that where appropriate, credit bureau reports may be obtained.

_____ _____

Patient Signature and/or Responsible Party (i.e. POA or Guarantor) Date

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# TRUE IMAGE
## ORTHODONTICS

*We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.*

*Thank You!*

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Patient Name _____ ❑ Male ❑ Female

Social Security # _____ Birth Date _____ Driver License # _____

Home Address _____

City _____ State _____ Zip _____

Primary Phone # _____ ❑home ❑cell Ok to leave Message? ❑Y ❑N

Secondary Phone # _____ ❑home ❑cell ❑other Ok to leave Message? ❑Y ❑N

Email Address _____

Employer's Name _____ Occupation _____

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Marital Status ❑ Single ❑Married ❑ Divorced ❑ Widowed ❑ Significant Other

Spouse/Partner's Name _____

Emergency Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Relation to you _____

Person(s) OK to release appointment or medically related information to concerning you.

_____ Relation _____

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Primary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security # _____ Policy Holder's Birth Date _____

Employer _____ Work Phone # _____

Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security # _____ Policy Holder's Birth Date _____

Employer _____ Work Phone # _____

Co-pay (if known) _____ Deductible (if known) _____