



T R U E I M A G E
O R T H O D O N T I C S

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

Your answers are for office records only, and are confidential. A thorough medical 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)

PATIENT NAME:

- 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?

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) _____

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 your child visited an orthodontist before? Y N
When? _____ Reason? _____
Have we treated any other family members? Y N Name _____
Have your child's tonsils or adenoids been removed? Y N
Has your child ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Y N
Does your child have any missing or extra permanent teeth? Y N
Has your child ever had an injury to (select all that apply): Teeth Mouth Chin
Does your child have speech problems? Y N If so, explain _____
Does your child currently or has your child ever had any of the following habits (check all that apply)
 Clenching/Grinding Teeth Mouth Breathing Thumb/ Finger Sucking
 Lip Sucking/Biting Nail biting Chewing/Eating Problem

Is your child currently being treated by a physician? Y N Reason _____
Physician _____ Last Visit _____ Phone _____
Does your child have any allergies/sensitivities to medications or latex? Y N If yes, please list.

Is your child currently taking any prescription or over-the-counter medications? Y N
Please list, with dosage. _____
Has puberty and/or menstruation begun? 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 child's medical status.
 - ❖ I hereby authorize the release of any information pertaining to my child's 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 _____

Date _____

CHINA



TRUE IMAGE ORTHODONTICS

We would like to welcome you and your child 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!

Patient Name _____ Male Female
 Social Security # _____ Birth Date _____ Age _____
 Home Address _____
 City _____ State _____ Zip _____
 Primary Phone # _____ home cell Ok to leave Message? Y N
 Email _____
 School _____ Grade _____
 List any sports or extracurricular activities _____
 Siblings (names and ages) _____

Parent's Marital Status Single Married Divorced Widowed Significant Other

Mother Step-Mother Guardian Other Name _____

Social Security # _____ Birth Date _____ Driver License # _____

Address (if different than child's) _____

City _____ State _____ Zip _____

Phone # _____ home cell Secondary Phone # _____ home cell

Employer's Name _____ Occupation _____

Father Step-Father Guardian Other Name _____

Social Security # _____ Birth Date _____ Driver License # _____

Address (if different than child's) _____

City _____ State _____ Zip _____

Phone # _____ home cell Secondary Phone # _____ home cell

Employer's Name _____ Occupation _____

Emergency Contact Name (other than parent) _____

Phone # _____ Relation to child _____

Address _____

City _____ State _____ Zip _____

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

_____ Relation(s) _____