



Voice: 727.446.8005  
Fax: 727.446.8002

**ADULT PATIENT CONTACT INFORMATION:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

*Main reason for pursuing treatment at our office?* \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Favorite Hobby: \_\_\_\_\_

Birthday: \_\_\_\_\_ Gender: (F) (M) SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Who is your General Dentist? \_\_\_\_\_ Last Visit? \_\_\_\_\_

**Account Holder information:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthday: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email address\*: \_\_\_\_\_

(\*We will only use this address to send you appointment reminders and office information.)

**Insurance Information:**

Employer: \_\_\_\_\_

Dental insurance for patient: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_

**Who may we thank for your visit:**

Dentist: \_\_\_\_\_ who? \_\_\_\_\_

Friend/Family: \_\_\_\_\_ Name? \_\_\_\_\_

Sign/Location: \_\_\_\_\_

Internet: \_\_\_\_\_

**Emergency contact:**

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details). Parents/Guardians please respond for minors.

- Yes No Are you taking any medication/supplements/herbals? \_\_\_\_\_
- Yes No Are you allergic to any medication/foods/latex/metals/acrylics/anesthetics etc? \_\_\_\_\_
- Yes No Do you have a history of a major illness? \_\_\_\_\_
- Yes No Have you had any major operations? \_\_\_\_\_
- Yes No Have you ever been involved in a serious accident? \_\_\_\_\_
- Yes No Are you/have you taking/taken bisphosphonates for osteoporosis or other bone diseases \_\_\_\_\_
- Yes No Do you chew or smoke tobacco products? If so, how long? \_\_\_\_\_
- Yes No Do you have or have you ever had a substance abuse problem \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

- |                              |                            |                          |                        |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes                   | Hepatitis/Liver problems | Pneumonia              |
| Anemia                       | Dizziness                  | Herpes                   | Prolonged Bleeding     |
| Arthritis                    | Epilepsy                   | High Blood Pressure      | Radiation/Chemotherapy |
| Asthma or Hayfever           | Gastrointestinal Disorders | HIV / AIDS               | Rheumatic Fever        |
| Bone Disorders               | Heart Problems             | Kidney problems          | Tuberculosis           |
| Congenital Heart Defect      | Heart Murmur               | Nervous Disorders        | Tumor or Cancer        |

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

**DENTAL HISTORY**

What concerns you most about your teeth? \_\_\_\_\_

- Yes No Are you happy with the appearance of your teeth? \_\_\_\_\_
- Yes No Are you presently in any dental pain? \_\_\_\_\_
- Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_
- Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_
- Yes No Have there been any injuries to face, mouth or teeth? \_\_\_\_\_
- Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_
- Yes No Do your gums bleed when you brush? \_\_\_\_\_
- Yes No Are you concerned about bad breath? \_\_\_\_\_
- Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_
- Yes No Are you a mouth breather? \_\_\_\_\_
- Yes No Do you have/have you had a tonsil or adenoid conditions? \_\_\_\_\_
- Yes No Have you been told you have a tongue thrust? \_\_\_\_\_
- Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_
- Yes No What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_
- Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_
- How did they feel about the result? \_\_\_\_\_
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_
- Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_
- Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_
- Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_
- Yes No Do you have "tension" headaches? \_\_\_\_\_
- Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_
- Yes No Are there any familial medical conditions we should know about? \_\_\_\_\_

**Female Patients only:**

- Yes No Are you pregnant? \_\_\_\_\_
- Yes No Has menstruation started (This is useful in monitoring/modifying growth of head and jaw bones)? \_\_\_\_\_

*Retention of Documents relating to your care:* By signing this, you understand that it is our policy to maintain original documents for a period of one (1) day after which our office, at its election, may scan and store documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed from the electronic form, has the same force and effect as the original document.

*Authorization and Release:* I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing inaccurate information can be dangerous to my health. I give Straighten Up Orthodontics permission to send recall reminders and to contact my home for appointment reminders.

\_\_\_\_\_  
XSignature of Patient

\_\_\_\_\_  
DATE



**HIPAA COMPLIANCE AND GENERAL CONSENT FORM**  
**HIPAA PRIVACY RIGHTS**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. I understand that by signing this consent, I authorize Straighten Up Orthodontics (“you”) to use and disclose my protected health information to carry out:

- \* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- \* Obtaining payment from third party payers (e.g., my insurance company); and
- \* The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of, your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However; if you do agree, you are then bound to comply with this restriction.

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.

**CONSENT FOR TREATMENT**

I hereby authorize Straighten Up Orthodontics and its employees, staff, and agents to take x-rays, study models, photographs and/or any other diagnostic aids deemed necessary by the treating orthodontist to make a thorough diagnosis of me or my dependent's dental needs.

Upon such diagnosis, I authorize Straighten Up Orthodontics to perform all recommended treatment agreed upon by me, and to give such assistance as required to provide proper care. **I understand that I may ask for a full explanation of any possible complications.**

Additionally, I authorize Straighten Up Orthodontics to contact me at all telephone numbers and addresses provided by me and updated by me, or available through public records.

**ADULT PATIENTS\_**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

**MINOR AGED OR INCOMPETENT PATIENTS:**

I, \_\_\_\_\_, am the parent with legal authority (not terminated by any court) or legal guardian with the legal authority to consent to the above for \_\_\_\_\_, DOB \_\_\_\_\_.

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**

\_\_\_\_\_  
**Date**