Freeman ORTHODONTICS

2050 Proctor Road, Suite A, Sarasota, Florida 34231 Phone (941) 953-7500

Patient's Name ________________________ M F DOB ____/____/____ SSN ____-____-____

Address ________________________ City ____________ Zip ________ Lives with Mom/Dad

Preferred Contact Phone (for appointment confirmations) ____________ Other # ____________

Patient's School ________________________ Grade ____________

Patient's Dentist ________________________ Date of Last Appointment ____________

Patient's Physician ________________________ Date of Last Appointment ____________

Father's Name ________________________ Mother's Name ________________________

Responsible Party's Name ________________________ DOB____/____/____ SSN ____-____-____

Address ________________________ City ____________ State ________ Zip ________

Responsible Party's Phone #(s) ________________________

Email Address (for appointment confirmations) ________________________

Dental Insurance? Y N Insurance Company________________________ Phone #____________

Subscriber's Name____________ DOB____/____/____ SSN ____-____-____ ID #____________

Referred by? ________________________

Reason for consultation ________________________

The purpose of this brief medical history form is to let our office know of any medical conditions that must be communicated prior to your (or your child's) initial oral exam.

Please list all medical conditions, illnesses or infectious diseases. **If no concerns, please circle → NONE.**

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Please list all current drugs/medications. **If no concerns, please circle → NONE.**

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Please list any drug allergies. **If none, please circle → NONE.**

____

Yes **No** Have there been any injuries to the face, mouth or teeth?

Yes **No** Heart murmur or valve concerns?

Yes **No** Need for antibiotic pre-medication prior to dental procedures?

Yes **No** Currently taking bisphosphonate medications (Fosamax, Boniva, Actonel, etc.)?

Yes **No** Latex Allergy?

Yes **No** Social Concerns Regarding Smile?

Yes **No** Possibility of pregnancy?

Yes **No** Metal Allergy?

Yes **No** Currently sucking thumb and/or fingers?

Yes **No** Suffer from sleep apnea?

I hereby give my permission and/or consent to have Dr. David Freeman and/or his staff to contact my/my child's healthcare providers as necessary to coordinate my orthodontic care.

________________________ ____________ ________________________

Signature of Responsible Party **Date** **Relationship to Patient**

Patient's Last Name ________________________________ First Name ____

Who suggested that you/your child might need orthodontic treatment? ______________________________________

Other family members treated here ____

Why did you select our office? ____

For the following questions mark yes or no. The answers are for office use only and will be considered confidential.

□ yes □ no Does the patient have learning disabilities or need extra help with instructions?
□ yes □ no Is the patient sensitive or self conscious about his/her teeth?
□ yes □ no Does the patient chew or smoke tobacco?

Now or in the past, has the patient had (if yes, please circle accordingly):

□ yes □ no Birth defects?
□ yes □ no Endocrine or thyroid problems?
□ yes □ no Kidney problems?
□ yes □ no Diabetes?
□ yes □ no Cancer, tumor, radiation treatment or chemotherapy?
□ yes □ no Problems of the immune system?
□ yes □ no Hepatitis, jaundice or liver problem?
□ yes □ no Fainting spells, seizures, epilepsy, or neurological problem?
□ yes □ no Mental health disturbance or depression?
□ yes □ no History of eating disorder (anorexia, bulimia)?
□ yes □ no Excessive bleeding, bruising tendency, or bleeding disorder?
□ yes □ no High or low blood pressure?
□ yes □ no Chest pain, shortness of breath or swollen ankles?
□ yes □ no Cardiovascular problem, congenital heart defects, heart murmur or rheumatic heart disease?
□ yes □ no Hayfever, asthma, sinus trouble or hives?
□ yes □ no Tonsil or adenoid conditions?
□ yes □ no Total joint (hip, knee, elbow, finger) replacement?
□ yes □ no Attention Deficit Hyperactivity Disorder (ADHD)?

Allergies or reactions to any of the following:

□ yes □ no Local anesthetics (Novocaine or Lidocaine)
□ yes □ no Ibuprofen (Motrin, Advil)
□ yes □ no Penicillin or other antibiotics
□ yes □ no Codeine or other narcotics
□ yes □ no Metals/Nickel (jewelry, clothing, snaps)
□ yes □ no Latex (gloves, balloons)
□ yes □ no Acrylic

Has the patient had any operations/hospitalizations? If so, please describe.

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Do you have any disease, condition, or problem not listed above? If so, please explain.

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Is the patient taking prescription medication, nutritional supplements, herbal medications or non prescription medicine? If so, please list.

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Do the patient's parents or siblings have any health problems? If so, please explain.

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Now or in the past, has the patient had:

□ yes □ no Permanent teeth removed?
□ yes □ no Congenitally missing permanent (adult) teeth?
□ yes □ no Injury to the primary (baby) or permanent teeth?
□ yes □ no Facial trauma or jaw fractures?
□ yes □ no Thumb, finger, or sucking habit? Until what age _______?
□ yes □ no History of speech problems?
□ yes □ no Any pain in jaw or ringing in the ears?
□ yes □ no Any pain or soreness in the muscles of the face or around the ears?
□ yes □ no Difficulty chewing or opening jaw?
□ yes □ no Aware or concerned about an under or overdeveloped jaw?
□ yes □ no Any relative with similar tooth or jaw relationships?
□ yes □ no Any periodontal (gum) disease or treatment?
□ yes □ no Ever had a prior orthodontic examination or treatment?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If yes, what antibiotic and dose?

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Has the patient been under another dental specialist's care (periodontist, endodontist)? If so, please explain.

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WOMEN ONLY

□ yes □ no Has the patient started her monthly periods? If so, how many years ago? _______
□ yes □ no Is the patient pregnant or possibly pregnant?

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

____ ____________________
Signature (Patient, Parent, or Guardian) **Date**

____ ____________________
Dental Team Member **Date**

Please review and accept or decline the consents below.

***X-rays** During treatment we often need to take an updated panoramic x-ray to evaluate dental development and tooth position; there is no additional charge for the x-ray. We will forward a copy of the x-ray to the patient's dentist. **Please give us your consent (or your parental consent) to take the needed x-rays by checking the appropriate box below.**

☐ **Accept** ☐ **Decline**

***Consent to Use Records (In Office Bulletin Facial Photo)** I authorize Freeman Orthodontics to use treatment records including facial photographs, intraoral photographs, x-rays, study models, and treatment notes for the following purposes: academic advancement, lectures and presentations, publications and internal marketing (bulletin board). You have the right to revoke this authorization at any time in writing.

☐ **Accept** ☐ **Decline**

***Social Marketing/Internet Consent** I authorize Freeman Orthodontics to use any photos of the above patient interacting in the office or in office events via our website or our Facebook page. This includes contest winners/participants and other activities **not** related with clinical treatment.

☐ **Accept** ☐ **Decline**

____ ____________________

Signature (Patient, Parent, or Guardian) **Date**

Notice of Privacy Practices for Freeman Orthodontics

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. The federal law gives you, the patient, significant new rights to understand and control how your heath information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed this Privacy Notice. A copy of this notice will be provided upon request.

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Signature (Patient, Parent, or Guardian) **Date**