Patient Information - Adult

Title _____ Legal Name _____
Preferred Name _____ DOB _____ Gender _____
Marital Status: Married ___ Single ___ Divorced ___ Spouse's Name _____
E-Mail Address _____
Cell Phone No. _____ Home Phone No. _____
Employer _____ Occupation _____
Hobbies/Interest _____
Referred by _____
Past or Present Family Members in Treatment _____
Have you Consulted an Orthodontist Before? _____ If so, when _____

Dental Insurance Information

Subscriber's Name _____ DOB _____
Address _____ Phone _____
Employer _____
Insurance Company _____ Phone _____
Group Number _____ Subscriber ID/SS# _____

Medical Insurance Information

Subscriber's Name _____ DOB _____
Address _____ Phone _____
Employer _____
Insurance Company _____ Phone _____
Group Number _____ Subscriber ID/SS# _____

Secondary Insurance : Dental ___ Medical ___ Both ___

Subscriber's Name _____ DOB _____
Address _____ Phone _____
Employer _____
Insurance Company _____ Phone _____
Group Number _____ Subscriber ID/SS# _____

The information provided on these forms is accurate to the best of my knowledge. If there are any further changes to the history, I will so inform the practice. I further give my authorization to release any and all office records and x-rays to this practice.

____ I understand that it is my responsibility to notify the office of any changes in my calling/insurance/mailing information.

Signature _____ Date _____

(Parent/Legal Guardian)

Dental History

Patient's Name_____DOB _____

Dentist's Name_____ Address _____

Date of Last Visit _____

Is there unfinished care to be completed by your dentist? Yes _____ No _____

Please explain: _____
_____
_____

What are the chief concerns you have related to the position of your teeth or bite?

Cleaning _____ Comfort _____ Ability to chew _____ Stability _____ Function _____ My Smile _____

Have you ever been told to take an antibiotic prior to dental visits? Yes ____ No ____

Please check if there is a history of:

___ Clenching teeth
___ Jaw joint soreness
___ Grinding teeth
___ Jaw joint clicking
___ Speech Problems
___ Muscular soreness around head and neck
___ Jaw joint popping
___ Headaches
___ Ringing in the ears
___ Mouth breathing
___ Snoring
___ Sleep Apnea
___ History of jaw surgery
___ History of trauma to teeth or face

If so, please explain: _____
_____
_____

What concern has your dentist expressed concerning your bite or dental alignment?

___ Wear or fractures of teeth
___ Alignment of teeth prior to restorative dental work
___ Difficulty with cleaning related to alignment of teeth
___ Jaw joint muscle tightness of discomfort
___ Bone or gum tissue loss
___ Snoring
___ Sleep Apnea
___ History of jaw surgery
___ History of trauma to the teeth or face

Please explain: _____
_____
_____

Patient/Parent Signature _____ Today's Date _____

Medical History

Patient's Name_____ DOB _____

Physician's Name _____ Address _____

Date of Last Physical Exam _____

Allergies or restrictions to any of the following:

Y __ N __ Aspirin, Ibuprofen or Tylenol
Y __ N __ Barbiturates
Y __ N __ Codeine or other narcotics
Y __ N __ Latex
Y __ N __ Local anesthetics
Y __ N __ Metals
Y __ N __ Penicillin or other antibiotics
Y __ N __ Plastic or vinyl
Y __ N __ Sedatives
Y __ N __ Sleeping pills
Y __ N __ Sulfa drugs
Y __ N __ Other

Medications:
Please list medications, nutrients supplements, herbal medications & non-prescription medicines currently being taken

Medication:_____ Taken For:_____

Medication:_____ Taken For:_____

Medication:_____ Taken For:_____

Medication:_____ Taken For:_____

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

Y __ N __ Adenoids or tonsils removed
Y __ N __ Arteriosclerosis (hardening of the arteries)
Y __ N __ Asthma, hay fever, sinus trouble or hives
Y __ N __ Autoimmune disorders or immune system problems
Y __ N __ Bleeding or bruising easily
Y __ N __ High or low blood pressure – please circle
Y __ N __ Cancer, tumor, chemotherapy or radiation treatment
Y __ N __ Chronic fatigue
Y __ N __ Current pregnancy
Y __ N __ Depression or other mental health disturbance
Y __ N __ Diabetes
Y __ N __ Dizziness
Y __ N __ Epilepsy or other seizure disorder
Y __ N __ Developmental disorder
Y __ N __ Fibromyalgia
Y __ N __ General anesthesia
Y __ N __ Hearing Impairment
Y __ N __ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y __ N __ Frequent coughs, colds or sore throats
Y __ N __ Hemophilia
Y __ N __ Hepatitis, AIDS or HIV positive
Y __ N __ Herpes (mouth sores)
Y __ N __ Injury to face, neck, mouth or teeth – please circle
Y __ N __ Insomnia
Y __ N __ Jaw joint surgery
Y __ N __ Kidney or liver problems
Y __ N __ Meniere's disease
Y __ N __ Multiple sclerosis
Y __ N __ Muscular dystrophy
Y __ N __ Nighttime breathing problems (snoring or sleep apnea)
Y __ N __ Nervousness
Y __ N __ Neuralgia
Y __ N __ Osteoarthritis (stiff or swollen joints)
Y __ N __ Osteoporosis
Y __ N __ Parkinson's disease
Y __ N __ Prior orthodontic treatment
Y __ N __ Psychiatric care
Y __ N __ Rheumatic fever
Y __ N __ Rheumatoid arthritis
Y __ N __ Scarlet fever
Y __ N __ Skin disorder
Y __ N __ Speech difficulties
Y __ N __ Stoke or heart attack
Y __ N __ Tuberculosis
Y __ N __ Wisdom teeth extraction
Y __ N __ Birth defects or hereditary problems
Y __ N __ Endocrine or thyroid problems
Y __ N __ Stomach ulcer or hyperacidity
Y __ N __ Polio, mononucleosis or pneumonia
Y __ N __ Vision problems
Y __ N __ Loss of weight recently, poor appetite
Y __ N __ Eating disorder (anorexia or bulimia)
Y __ N __ Chest pain, shortness of breath or swelling ankles
Y __ N __ Frequent or severe headaches
Y __ N __ Other condition

If yes, please explain _____

Emergency Contact _____ Relationship _____ Phone # _____

Patient/Parent Signature _____ Today's Date _____

CONSENT FOR USE AND
DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient's Legal Name _____

Section B: To the Patient – Please Read these Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use an disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request with this Consent. We encourage you to read it carefully and completely before signing this Consent.

Office Procedures: As a part of the practice procedures our doctors reserve the right to use patient photographs, x-rays, videos and other photographic reproductions for the purpose of professional academic education and practice promotion, including use on website, brochures and social media sites.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will make available upon request a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person: Lisa Leroux
Telephone: 860-561-5358
Email: bracesonbracerd@snet.net
Address: 36 Brace Road
West Hartford CT 06111

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice or your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Section C: Signature

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient/Parent/Guardian Signature: _____ Date _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

We would love for you to join the Ritoli Orthodontics Family!

We have an informative Website, Facebook page and Instagram account to keep you up to date on all things happening.

We will invite you to our many Community Events, cheer on achievements and share fun activities going on at our office.

___ Yes, I give permission to use photos taken at our events and in our office.

___ No, I would prefer that you did not use photos taken at our events and in our office.

Signature_____Date _____
Patient/Guardian

Please find us at: *www.BracesOnBraceRd.com*

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