Dr. Mike Adkins
SPECIALIST IN ORTHODONTICS

Member American Association of Orthodontists

CONFIDENTIAL

PATIENT INFORMATION

Date: _____

Patient Name: _____
First Last (Name Called)

Birthday: _____ Grade: _____

Home Phone: _____ Cell Phone: _____ email: _____

Address: _____

City, State, Zip Code: _____

Sex: ☐Male ☐Female SSN: _____

Dentist: _____ Physician: _____

Who referred you to our practice? _____

Any Medical Problems? _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
First Last (Name Called)

Birthday: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City, State, Zip Code: _____

Sex: ☐Male ☐Female SSN: _____

Is this Responsible Party Financially Responsible for Charges? ☐Yes ☐No

Insurance Company: _____

Group Number: _____ Employer: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
First Last (Name Called)

Birthday: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City, State, Zip Code: _____

Sex: ☐Male ☐Female SSN: _____

Is this Responsible Party Financially Responsible for Charges? ☐Yes ☐No

Insurance Company: _____

Group Number: _____ Employer: _____

GENERAL INFORMATION

What concerns you about your/your child's teeth? _____

How do you feel about orthodontic treatment? _____

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

Why did you select our office? _____

Describe any previous orthodontic treatment. _____

Does the patient play a musical instrument? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐Yes ☐No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

MEDICAL HISTORY

Now or in the past, has the patient had:

☐Yes ☐No ☐dk/u Any injuries to face, head, neck?
☐Yes ☐No ☐dk/u Arthritis or joint problems?
☐Yes ☐No ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐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 Immune system problems?
☐Yes ☐No ☐dk/u History of osteoporosis?
☐Yes ☐No ☐dk/u Gonorrhea, syphilis, herpes, or sexually transmitted diseases?
☐Yes ☐No ☐dk/u AIDS or HIV positive?
☐Yes ☐No ☐dk/u Hepatitis, jaundice or other liver problems?
☐Yes ☐No ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐Yes ☐No ☐dk/u Seizures, fainting spells, neurological problem?
☐Yes ☐No ☐dk/u Mental health disturbance or depression?
☐Yes ☐No ☐dk/u History of eating disorder (anorexia, bulimia)?
☐Yes ☐No ☐dk/u Frequent headaches or migraines?
☐Yes ☐No ☐dk/u High or low blood pressure?
☐Yes ☐No ☐dk/u Excessive bleeding or bruising tendency, 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 Vision, hearing, or speech problems?
☐Yes ☐No ☐dk/u Frequent ear infections, colds, throat infections?
☐Yes ☐No ☐dk/u Asthma, sinus problems, hay fever?
☐Yes ☐No ☐dk/u Tonsil or adenoid condition?
☐Yes ☐No ☐dk/u Frequently breathe through the mouth?

If you answered yes to any of the above questions, please explain.

_____

_____

_____

DENTAL HISTORY

Now or in the past, has the patient had:

☐Yes ☐No ☐dk/u Permanent/extra teeth removed?
☐Yes ☐No ☐dk/u Extra/congenitally missing teeth?
☐Yes ☐No ☐dk/u Tooth grinding or clenching?
☐Yes ☐No ☐dk/u Clicking, locking in jaw joints?
☐Yes ☐No ☐dk/u Soreness in jaw/face muscles?
☐Yes ☐No ☐dk/u Been treated for TMJ/TMD?

How often does the patient brush? _____
How often does the patient floss? _____

☐Yes ☐No ☐n/a Are you pregnant or trying to become pregnant?

FAMILY HISTORY

Have any family members ever had any of the following health problems? If so, please explain.

☐Yes ☐No ☐dk/u Bleeding disorders
☐Yes ☐No ☐dk/u Diabetes
☐Yes ☐No ☐dk/u Arthritis
☐Yes ☐No ☐dk/u Severe allergies
☐Yes ☐No ☐dk/u Unusual dental problems
☐Yes ☐No ☐dk/u Jaw size imbalance
☐Yes ☐No ☐dk/u Other family medical conditions?

Has the patient had allergies or reactions to any of the following?

☐Yes ☐No ☐dk/u Local anesthetics
☐Yes ☐No ☐dk/u Antibiotics
☐Yes ☐No ☐dk/u Acrylics
☐Yes ☐No ☐dk/u Latex
Other: _____

List any medications, nutritional substances, herbal medications or non-prescription medicines, including fluoride substances.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

RELEASE AND WAIVER

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

Patient/Parent Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any change's in my medical or dental health.

Patient/Parent Signature _____ Date _____

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Patient Health History Addendum

Patient Name: _____
First Middle Last Nickname

Dentist: _____

Have you traveled out of the country in the past year? If so, where?

Have you traveled to Liberia, Sierra Leone, or Guinea in the past 3 weeks?

Signed: _____ Date: _____
Parent/Guardian/Self

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PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date:**_____

I, the undersigned, hereby authorize Michael D. Adkins, DMD, MS to disclose certain protected health information about the patient listed above to any and all dental practitioners involved in this patient's care, and any and ALL financially responsible parties including but not limited to insurance companies, and financially responsible parties as per the signed pay agreement.

Michael D. Adkins, DMD, MS is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.): All Medical Records, All Dental/Orthodontic Records, All X-Rays, and Specific Information as Listed Below:

_____

_____

_____

_____

I understand that this request does not apply to: (1) certain health information that is not held in Michael D. Adkins, DMD, MS's medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

This authorization will expire upon completion of treatment with Michael D. Adkins, DMD, MS, unless expressly revoked by me/the patient at an earlier time.

I understand that Michael D. Adkins, DMD, MS may not condition my/the patient's treatment on whether I sign this authorization.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I/the patient may revoke this authorization at any time by delivering a revocation in writing to Michael D. Adkins, DMD, MS at the address listed above, and if I/the patient revokes this authorization, it will have no effect on actions already taken by Michael D. Adkins, DMD, MS in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient or Legal Guardian: _____ Date: _____

Patient Name: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Phone: _____

Printed Name of Patient or Legal Guardian: _____

Witness: _____

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

Michael D. Adkins, D.M.D., M.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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