Clark ORTHODONTICS, Inc.

Your Smile. Our Passion. Your Life.

## New Patient Health History

| Patient Biographical Information | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | Nickname: |
| Birth date: | Gender: | Social Security #: | |
| Address: | City: | State: | Zip: |
| Main Phone: | 2nd/Cell Phone: | Email: | |
| Please list the names of any friends or family currently in the practice: | | | |
| List any sports, hobbies, or musical instruments played: | | | |
| Whom may we thank for referring you to our practice? | | | |

| Parent Information | | | |
|---|---|---|---|
| **Mother's** First Name: | **Mother's** Middle Initial: | **Mother's** Last Name: | |
| Address: | City: | State: | Zip: |
| Main Phone: | 2nd/Cell Phone: | Email: | |
| Social Security #: | Date of Birth: | Employer/Occupation: | |
| Length of Employment: | Work Phone: | Relationship to Patient: | |

| | | | |
|---|---|---|---|
| **Father's** First Name: | **Father's** Middle Initial: | **Father's** Last Name: | |
| Address: | City: | State: | Zip: |
| Main Phone: | 2nd/Cell Phone: | Email: | |
| Social Security #: | Date of Birth: | Employer/Occupation: | |
| Length of Employment: | Work Phone: | Relationship to Patient: | |

| Insurance |
|---|

| | |
|---|---|
| Do you have insurance that covers orthodontics? | If so, please name the Primary Insurance Company: |
| Do you have Secondary Insurance? | If so, please name the Insurance Company: |

| Dental History | | | | | |
|---|---|---|---|---|---|
| Dentist Name: | | | | | |
| Check-up Frequency: | | | Last Dental Visit: | | |
| Has the patient had an orthodontic consult or treatment? | | | If so, when? | | |
| **What is the patient's main orthodontic concern?** | | | | | |
| Speech problems/therapy? | Yes | No | Brush teeth daily? | Yes | No |
| Grind or clench teeth? | Yes | No | Floss teeth daily? | Yes | No |
| Oral habits (thumb/finger habit, lip/nail biting)? | Yes | No | Fluoride treatments? | Yes | No |
| Injury to face, jaw, teeth, or mouth? | Yes | No | Mouth breathing? | Yes | No |
| Discomfort from teeth or gums? | Yes | No | Snores during sleep? | Yes | No |
| Pain, tenderness, or noise in either jaw? | Yes | No | Requires premedication? | Yes | No |
| Frequent headaches? | Yes | No | Any missing or extra permanent teeth? | Yes | No |
| Neck/shoulder pain? | Yes | No | Apprehensive about dental care? | Yes | No |
| Frequent sore throats? | Yes | No | Frequently chews gum? | Yes | No |
| If any of the above dental questions were answered "Yes," please explain: | | | | | |

| Medical History | | | | | | | |
|---|---|---|---|---|---|---|---|
| Physician Name: | | | Date of last Physical: | | | Patient Health: | |
| Address: | | City: | | State: | | Zip: | |
| List any medications currently being taken by the patient: | | | | | | | |
| List any drug allergies or sensitivities that the patient may have: | | | | | | | |
| Rheumatic Fever | Yes | No | Cancer | Yes | No | | |
| Tuberculosis/Lung Disease | Yes | No | Family History of Cancer | Yes | No | | |
| Pneumonia | Yes | No | Received Radiation Treatment | Yes | No | | |
| Liver Disease | Yes | No | Growth Problems | Yes | No | | |

| | | | | | |
|---|---|---|---|---|---|
| Kidney Disease | Yes | No | Endocrine Problems | Yes | No |
| Heart Attack/Stroke | Yes | No | Hormone Therapy | Yes | No |
| Heart Disease | Yes | No | Latex/Metal Allergy | Yes | No |
| Congenital Heart Defect | Yes | No | Nervous Disorders | Yes | No |
| Heart Murmur | Yes | No | Bone Disorders/Bone Loss | Yes | No |
| Hemophilia | Yes | No | Diabetes | Yes | No |
| Hypertension/High Blood Pressure | Yes | No | Seizures/Epilepsy | Yes | No |
| Prolonged Bleeding/Transfusion | Yes | No | Handicaps/Disabilities | Yes | No |
| Anemia | Yes | No | Asthma | Yes | No |
| HIV/AIDS | Yes | No | Arthritis | Yes | No |
| Hepatitis | Yes | No | Treated for Emotional Problems | Yes | No |
| Tonsils/Adenoids Removed | Yes | No | Ever Been Hospitalized | Yes | No |
| If any of the above medical questions were answered "Yes," please explain: | | | | | |

| **Patients Under 18** | | | |
|---|---|---|---|
| Please list the name and birth date of any siblings: | | | |
| Height: | Weight: | School: | Grade: |

| | | |
|---|---|---|
| Has patient begun puberty? | Yes | No |
| If patient is a girl, has menstruation begun? | Yes | No |
| If patient is a boy, has their voice changed or have facial hair? | Yes | No |
| Patient's interest in treatment? | Yes | No |
| Has either biological parent ever had orthodontic treatment? | Yes | No |

# Acknowledge of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

*Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly or indirectly.
*Obtain payment from third party payers and confirm coverage.
*Conduct normal healthcare operations such as quality assessments and physician certifications.
*Confirm appointments using email, text, voicemail, postcards, or letters.
*Disclose health information to a family member, friend, or caregiver to the extent necessary to help you with your healthcare.

I acknowledge that I have read and/or received the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or healthcare information. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Signature of Patient (or Guardian if under 18)_____

Date_____