ORTHODONTICS of ATLANTA
Your Smile is our Specialty!

PATIENT INFORMATION

Date____/____/_____

Patient's name _____
First Last Middle Birthday

Address _____
Street City Zip

Cell Phone_____ Carrier _____ Social Security # _____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office? _____

How would you like your appointment confirmed? ___Email addess _____ Text ____ Both ____

RESPONSIBLE PARTY INFORMATION

Name _____
First Last Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone_____ Work phone_____

Cell phone_____ Phone Carrier _____Email address _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate_____ Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

HIPAA COMPLIANCE PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

By signing this form, I understand that:
Protected health information may be disclosed or used for treatment, payment, or healthcare operations; the practice reserves the right to change the privacy policy as allowed by law; the practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions; the patient has the right to revoke this consent in writing at any time and all full disclosures will then cease; the practice may condition receipt of treatment upon execution of this consent.

This consent was signed by (PRINT NAME PLEASE) : _____
Parent/Guardian needs to sign if the patient is under 18 years of age.

Signature: _____ Date: _____

MEDICAL HISTORY

Patient's name _____

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication, latex or nickel containing metal? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____

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

General Dentist _____ Date of last visit _____
General Dentist Office Phone Number? _____

Please circle Yes or No (If Yes, please fill in details)

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? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
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? _____
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 grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Are you aware that some appointments will be during school/work hours? _____

Yes No Female Patients only:
Are you pregnant? _____

What is your main concern that you would like to accomplish with orthodontics? _____

_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize the Orthodontists at Orthodontics of Atlanta to perform a complete orthodontic evaluation.

Signature: _____ Date: _____