Patient Health Form

Sakowitz Smiles

About You

Date:_____

Name:_____ Gender:_____

Birth Date:_____ Age:_____ SS#:_____

Home #:_____

Cell #:_____

Address:_____

Email:_____

You may contact me with: ☐ ***Email*** ☐ ***Phone*** ☐ ***Both***

Employer:_____

Emp. Address:_____

How long?_____ Occupation:_____

Best time to reach you?_____

How did you hear about us?

_____

May we thank this person for referring you? ***Yes*** ☐ ***No*** ☐

Spouse Information

Name:_____

Employer:_____

Cell #:_____ Wk#:_____

Birthdate:_____ SS#_____

Insurance Information

Orthodontic Coverage: ***Y*** ☐ ***N*** ☐

Dental Coverage: ***Y*** ☐ ***N*** ☐

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:_____

Group # (Plan, Local or Policy #):_____

Insurance Holder Name:_____

Relation:_____

Insurance Holder Birthdate:_____

Insurance Holder ID#:_____

Insurance Holder Employer:_____

Medical History

Do you currently have a personal physician? ***Y*** ☐ ***N*** ☐

Your current physical health is: ***Good*** ☐ ***Fair*** ☐ ***Poor*** ☐

Physician Name:_____

Physician Phone #:_____

Current Dentist:_____

Date of last visit:_____

Are you currently under the care of a physician? Please explain:

_____

Are you taking prescribed or over -the-counter drugs? ***Y*** ☐ ***N*** ☐

Please list medications you are currently taking:

_____

Women, are you using prescribed birth control? ***Y*** ☐ ***N*** ☐

Are you pregnant? ***Y*** ☐ ***N*** ☐ Week:_____

Are you nursing? ***Y*** ☐ ***N*** ☐

Please list authorized persons with whom we may discuss your **Protected Health Information (PHI).** *Please notify us if you desire to remove a name from this list in the future.*

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Have you ever had any of the following medical issues?

Y ☐ ***N*** ☐ Abnormal Bleeding
Y ☐ ***N*** ☐ Anemia
Y ☐ ***N*** ☐ Artificial Bones/Joints/Valves
Y ☐ ***N*** ☐ Arthritis
Y ☐ ***N*** ☐ Blood Transfusion
Y ☐ ***N*** ☐ Cancer/Chemotherapy
Y ☐ ***N*** ☐ Congenital Heart Defect
Y ☐ ***N*** ☐ Asthma
Y ☐ ***N*** ☐ Diabetes
Y ☐ ***N*** ☐ Difficulty Breathing
Y ☐ ***N*** ☐ Convulsions/Epilepsy
Y ☐ ***N*** ☐ Drug/Alcohol Abuse
Y ☐ ***N*** ☐ Emphysema
Y ☐ ***N*** ☐ Herpes/Fever Blisters
Y ☐ ***N*** ☐ Frequent/Severe Headaches
Y ☐ ***N*** ☐ Glaucoma
Y ☐ ***N*** ☐ Heart attack/Murmur
Y ☐ ***N*** ☐ Venereal Disease
Y ☐ ***N*** ☐ Heart Surgery/Pacemaker
Y ☐ ***N*** ☐ Hemophilia
Y ☐ ***N*** ☐ Hepatitis
Y ☐ ***N*** ☐ High/Low Blood Pressure
Y ☐ ***N*** ☐ HIV+/AIDS
Y ☐ ***N*** ☐ Hospitalized (Other than childbirth)
Y ☐ ***N*** ☐ Mitral Valve Prolapse
Y ☐ ***N*** ☐ Kidney/Liver Problems
Y ☐ ***N*** ☐ Psychiatric Issues
Y ☐ ***N*** ☐ Rheumatic/Scarlet Fever
Y ☐ ***N*** ☐ Radiation Treatment
Y ☐ ***N*** ☐ Shingles
Y ☐ ***N*** ☐ Sickle Cell/Traits
Y ☐ ***N*** ☐ Sinus Issues
Y ☐ ***N*** ☐ Stroke
Y ☐ ***N*** ☐ Tuberculosis
Y ☐ ***N*** ☐ Ulcers

Medical History (Continued)

PLease list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

- Y ☐ N ☐ Aspirin
- Y ☐ N ☐ Codeine
- Y ☐ N ☐ Metals/Plastics
- Y ☐ N ☐ Dental Anesthetics
- Y ☐ N ☐ Erythromycin
- Y ☐ N ☐ Latex
- Y ☐ N ☐ Penicillin
- Y ☐ N ☐ Tetracycline
- Y ☐ N ☐ Other

PLease list any other drug or material allergies:

_____

_____

Dental History

What would you like us to accomplish with your smile?

_____

_____

Have you ever had or been evaluated for orthodonitc treatment?	Y ☐ N ☐
Have you ever had a serious/difficult problem associated with any previous dental work?	Y ☐ N ☐
Do you have any current pain, or experienced any pain or discomfort in your jaw joint?	Y ☐ N ☐
Do you like your smile?	Y ☐ N ☐
Do your gums bleed?	Y ☐ N ☐
Have you ever had an injury to your mouth, teeth or chin?	Y ☐ N ☐
Do you breathe through your mouth?	Y ☐ N ☐
Do you have any missing or extra permanent teeth?	Y ☐ N ☐
Have you ever taken Fosamax or any other bisphosphonate?	Y ☐ N ☐
Have you ever taken Phen-Fen?	Y ☐ N ☐
Do you smoke or use tobacco in any form?	Y ☐ N ☐

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, CDC and ADA.

OFFICE USE ONLY

I verbally reviewed the information above with the patient.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ Printed Name _____ Date

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and is my responsibility to inform this office of any changes to my medical status. I authorize the staff to perform the necessary services that I may need.

_____ Signature _____ Date

I received a copy of the Notice of Privacy Practices of Sakowitz Smiles Orthodontics. I hereby authorize, as indicated by my signature, Sakowitz Smiles Orthodontics to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent Form.

_____ Signature _____ Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered. I am also responsible for paying any co-payment/deductibles that my insurance does not cover. I hereby authorize payment of group insurance benefits directly to this office.

_____ Signature _____ Date

Embrace your best self!

PATIENT CONSENT

Clinical

1. I authorize Sakowitz Smiles Orthodontics, to perform all recommended treatment. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

2. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

3. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

4. A $25 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hour notice of cancellation is required.

Insurance

5. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

6. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____
Patient's Address: _____
If patient is a child, please provide the parental or legal guardian's consent:
Signature: _____ Relationship: _____ Date: _____