PUTNAM ORTHODONTICS

How did you hear about us?

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know **ALL** the ways you heard about our office.

Put a check next to each source and then **CIRCLE** the main reason you selected this office.

Thank you!

Patient Name: _____

__ Dentist

__ Internet

__ Family Member/Sibling

__ Office Incentive (Ortho Bucks, contests)

__ Insurance company

__ Sports teams/ Sponsorship

__ Direct mailings

__ Newspaper

__ Other: _____

Please list all of your friends that referred you here so we may thank them properly:

1. _____
2. _____
3. _____

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Patient Information

Patient's Name: _____ Sex:_____ DOB:_____

Address: _____

Home Phone:_____ Cell Phone:_____

Email:_____

Would you prefer appointments confirmed by phone or email? (if phone which #)_____

Who may we thank for recommending us? _____

School if Student:_____ Grade:_____

Employer/Occupation:_____

Name of Dentist:_____ City:_____ Date of Last Visit:_____

Name of Physician:_____

Patient's Hobbies:_____

Please Complete if Billing Party is Different from Patient

Billing Party's Full Name:_____

Billing Party's Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Fax:_____

Occupation/Employer:_____

Relationship to Patient:_____

Thank you for your time ☺

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Primary Insurance

Insured's Name:_____

Insured's Social Security No.:_____

ID No.:_____

Insured's Employer:_____

Insurance Co. Name:_____

Insurance Co. Phone No.:_____

Insurance Co. Address:_____

_____

Insured's Date of Birth:_____

Secondary Insurance

Insured's Name:_____

Insured's Social Security No.:_____

ID No.:_____

Insured's Employer:_____

Insurance Co. Name:_____

Insurance Co. Phone No.:_____

Insurance Co. Address:_____

Insured's Date of Birth:_____

Medical History Dental History

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Please check if the patient has or has had: [Y] [N] [ ] [ ] Joint Swelling [ ] [ ] Bone Disorders [ ] [ ] Heart Trouble [ ] [ ] Mitral Valve Prolapse [ ] [ ] Rheumatic Trouble [ ] [ ] Thyroid Problems [ ] [ ] Diabetes [ ] [ ] Emotional Problems [ ] [ ] Brain Injury [ ] [ ] Kidney or Liver Involvement [ ] [ ] Joint Prosthesis	[Y] [N] [ ] [ ] Tuberculosis [ ] [ ] Anemia [ ] [ ] Epilepsy [ ] [ ] Prolonged Bleeding [ ] [ ] Faintness/Dizziness [ ] [ ] Tonsils Removed [ ] [ ] Adenoids Removed [ ] [ ] Sore Throat [ ] [ ] Tonsillitis [ ] [ ] Earaches [ ] [ ] Arthritis	**Please check Yes or No:** [Y] [N] [ ] [ ] Any injuries to face, mouth, teeth? (circle) [ ] [ ] Thumb, finger, lip, sucking? (circle) [ ] [ ] More than average amount of decay? [ ] [ ] Any missing permanent teeth? [ ] [ ] Any extra permanent teeth? [ ] [ ] Any teeth removed by extraction? [ ] [ ] Any difficulty in swallowing or chewing? [ ] [ ] Any pain or clicking when opening mouth? [ ] [ ] Is patient adopted? At what age?_____ [ ] [ ] Does patient visit the dentist regular? Date of last visit:_____ [ ] [ ] Has an orthodontist been consulted previously? Reason:

Approximately how much has the patient grown in the last year?	Have you or any member of your family or close relative had: Rheumatoid Arthritis: [ ]Yes [ ]No Lupus [ ]Yes [ ]No
What would you like orthodontic treatment to accomplish?	
List any serious illnesses:	
List any allergies (such as metals, latex, aspirin, codeine, Motrin/Advil, anesthetics, etc):	
List drugs or medication now being taken:	
Is patient presently under physicians care? Reason:	
Name of Primary Physician:	Name of other Physician(s):

To the best of my knowledge, the above information is complete and correct. If there are any changes in health or medication, I will inform Dr. Pai.

_____ _____

Signature of Patient or Parent or Guardian if Patient is a Minor Date

PATIENT HIPPA AWARENESS

PUTNAM ORTHODONTICS

With my permission, Putnam Orthodontics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (PHO). Please refer to Putnam Orthodontics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Putnam Orthodontics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained forwarding a written request to the Privacy Office.

With my permission, the office of Putnam Orthodontics may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out PHO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Putnam Orthodontics may mail to my home or other designated location any items that assist the practice in carrying out PHO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Putnam Orthodontics may e-mail to my home or other designated location any items that assist the practice in carrying out PHO, such as appointment reminder cards and patient statements. I have the right to request that Putnam Orthodontics restrict how it uses or discloses my PHI to carry out PHO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Putnam Orthodontics to use and disclosure my PHI for PHO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date