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. __________________________

PUTNAM ORTHODONTICS

Patient Information

Patient's Name: ____________________________Nick 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 (sports, music, activities, etc.):____

Parental Information: Please complete if patient is a minor

Father's Name:__________________________

Address (if different):_____________________

Home Phone:____________________________

Cell Phone:______________________________

Work Phone: ____________________________

Fax:____________________________________

Occupation/Employer:_____________________

Mother's Name:__________________________

Address (if different):_____________________

Home Phone:____________________________

Cell Phone:______________________________

Work Phone: ____________________________

Fax:____________________________________

Occupation/Employer:_____________________

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:____

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Medical History | Dental History

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

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