Rad Orthodontics

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Mehdy Rad, D.M.D., PC

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle _____ (Initial) SEX ☐ M ☐ F BIRTHDATE _____ AGE _____

If Patient is a Minor, give Parent's or Guardian's Name _____ Reason for this Visit _____

Whom may We Thank for Referring You to our Office? _____ TODAY'S DATE _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle _____ Marital Status _____

RESIDENCE Street _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME # _____ WORK # _____ CELL # _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____

E-MAIL ADDRESS _____

S.S. # _____ BIRTHDATE _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____

EMPLOYER _____ NO. YEARS EMPLOYED _____

OCCUPATION _____ S.S. # _____

WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION: (Relative **NOT** Living with You)

NAME _____ (Last / First / Middle)

ADDRESS _____

CITY _____ STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION: (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's S.S. # _____ Group # _____ Local # _____

DENTAL INSURANCE INFORMATION: (Secondary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's S.S. # _____ Group # _____ Local # _____

It is important that I know about your Dental and Medical History. This information is strictly confidential and will not be released to anyone. These facts have a direct bearing on your Dental Health. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
Name of General Dentist:		
City: State:		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, Date: (16 small Films or Panoramic)		
Extra or Congenitally MISSING teeth?	☐	☐
Abnormal SWALLOWING habit?	☐	☐
MOUTH BREATHING habit, snoring or difficulty breathing?	☐	☐
Concerned about SPACED, CROOKED or PROTRUDING teeth?	☐	☐
Have you had any PERIODONTAL (Gum) treatments?	☐	☐
Do your gums BLEED, feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle one)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐

What is your primary REASON for TODAY'S VISIT?

Please list ANY other DENTAL or MEDICAL information that you feel I should know about.

Patient Signature (Parent of Child) _____

MEDICAL HISTORY	YES	NO
Do you have any current HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
If so, please explain: _____		
What MEDICATIONS are you currently taking? _____		
Are you PREGNANT?	☐	☐
Do you SMOKE?	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

AIDS/ARC/HIV+	Diabetes	Kidney Trouble
Alcoholism	Drug Addiction	Liver Disease
Allergies or Hives	Emphysema	Mitral Valve Prolapse
Anemia	Epilepsy or Seizures	Nervousness
Angina Pectoris	Fever Blisters	Pain in Jaw Joint
Arthritis	Glaucoma	Psychiatric Treatment
Artificial Heart Valve	Hay Fever	Radiation Treatment
Artificial Joint (Hip, Knee)	Heart Disease or Attack	Rheumatic Fever
Asthma	Heart Murmur	Sinus Trouble
Blood Transfusion	Heart Pacemaker	Stroke
Bruise Easily	Heart Surgery	Thyroid Disease
Chemotherapy (Cancer, Leukemia)	Hemophilia (bleeding problem)	Tuberculosis (TB)
Congenital Heart Lesion	Hepatitis A (infectious)	Ulcers
Cortisone Medicine	Hepatitis B (serum)	Venereal Disease (Syphilis, Gonorrhea, etc.)
Cosmetic Surgery	High Blood Pressure	

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES?

If so, please list: _____

Family Physician _____ Phone # _____

PATIENT CONSENT

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

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as assessments and physician certifications.

I have been informed by you of your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***Notice of Privacy Practices*** prior to signing this consent. I understand that this organization has the right to change it's ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address below 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 out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions. If you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

MEDICAL HISTORY UPDATE/CHANGES

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

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