Gordon S. Groisser D.D.S. M.S.D. P.C

Orthodontic - Health Questionnaire and Patient Information for adult

General Information

Date_____ e-mail address_____

Name_____

Sex ☐ M ☐ F Birth Date _____ Age_____

Address_____

City _____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

☐ would like to receive appointment reminders via text

Cell Number:_____

Name of person responsible for account:

_____

Address:_____

City:_____ State:_____Zip Code_____

Dentist_____

Physician_____

Referred to this office by_____

Date of last dental appt._____

Did dentist take x-rays at that time? ☐Yes ☐No

Were all cavities filled? ☐Yes ☐No

School or place of employment_____

Has any member of your family had orthodontic treatment before? ☐Yes ☐No

If yes, indicate treatment results: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

A. What are your main concerns regarding the jaws and teeth?

Yes	No	
☐	☐	Crowding
☐	☐	Overbite
☐	☐	“Buck” teeth
☐	☐	Receded jaw
☐	☐	Prominent jaw
☐	☐	Gummy smile
☐	☐	Spaces
☐	☐	Gum disease/recession
☐	☐	Missing teeth
☐	☐	Jaw dysfunction
☐	☐	Mouth too small
☐	☐	Clicking jaw joint
☐	☐	Irregularly shaped teeth
☐	☐	Protrusion of teeth
☐	☐	Ringing/Stuffiness of ears
☐	☐	Headaches/Facial pain
☐	☐	Neck pain
☐	☐	Jaw pain
☐	☐	Irregular facial proportions
☐	☐	Other_____

B. Other Family members with similar orthodontic condition?

☐ Father ☐ Mother ☐ Brother
☐ Sister ☐ Other

C. Marital status

☐ Married ☐ Divorced ☐ Separated
☐ Single ☐ Widowed

D. Medical/Dental History

1. Present health

	Good	Fair	Poor
a. Physical	☐	☐	☐
b. Emotional	☐	☐	☐

2. Are you pregnant? ☐Yes ☐No Due date:_____
3. Have you ever had any of the following conditions?

☐ Allergies ☐ Arteriosclerosis
☐ Asthma ☐ Autoimmune disorder
☐ Blood disease ☐ High Blood Pressure
☐ Bone disorders ☐ Low Blood Pressure
☐ Cancer ☐ Convulsions
☐ Diabetes ☐ Dizziness
☐ Epilepsy ☐ Tuberculosis
☐ Endocrine problems (type)_____
☐ Emotional problems ☐ Female problems
☐ Hepatitis ☐ Heart disease
☐ Hearing disease ☐ Kidney disease
☐ Rheumatic fever ☐ Ringing of ear
☐ Sleep disturbance ☐ Impaired sight/hearing
☐ Received trauma (teeth, face, jaws, or head)
☐ Venereal disease

E. **MEDICATION: Current medications:**

☐ Antibiotics	☐ Heart pills
☐ Diet pills (diuretics)	☐ Pain pills (demorol, codeine, etc.)
☐ Vitamins	☐ Birth control pills
☐ Sleeping pills	☐ Muscle relaxants
☐ Insulin	☐ Other_____

F. **ALLERGIES TO MEDICATION/FOOD:**

Have you demonstrated an allergic response to:

☐ Antibiotics (specific)
☐ Previous
☐ Presently

G. **The following are also of interest to the orthodontist.**

Do you:

	Yes	No
1. Snore when sleeping	☐	☐
2. Breath though the mouth? (mouth breather rather than nose breather) ☐ Seldom ☐ Sometimes ☐ Usually		
3. Drink more than 1 glass of milk per day	☐	☐
4. Have frequent colds?	☐	☐
5. Have frequent sore throats or tonsillitis?	☐	☐
TMJ		
6. Have speech problems?	☐	☐
7. Have difficulty chewing	☐	☐
8. Have pain in the jaw joint?	☐	☐
9. Does your jaw “lock”?	☐	☐
10. Have clicking in jaw joint?	☐	☐
11. Do your jaws feel “tired” after waking	☐	☐
12. Have difficulty swallowing?	☐	☐

H. **The following are of interest to the orthodontist:**

1. Finger sucking
   ☐ Never
   ☐ Previous
   ☐ Presently

	Yes	No
2. Lip biting or sucking?	☐	☐
3. Grinding of teeth?	☐	☐
4. Tongue thrusting?	☐	☐
5. Smoking?	☐	☐

6. Dental checkups
   - ☐ Twice a year
   - ☐ Once a year ☐ Never
   - ☐ Only if urged

	Yes	No
7. Have you had previous orthodontic consultation or treatment?	☐	☐
8. Have you had any dental experience?	☐	☐
9. Have you had any permanent or baby teeth removed?	☐	☐
10. Are there any medical dental, or surgical problems not covered above?	☐	☐

Remarks_____

K. **Have you experienced any major falls, accidents or operations? (particularly around the face)** If yes, indicate_____

_____

L. Are you being treated for osteoporosis or taking medication known as Biphosphonate? ☐Yes ☐No

M. HAVE YOU TESTED HIV POSITIVE OR ARE YOU AFFECTED BY AIDS?
☐ **YES** ☐ **NO**

INSURANCE

This section applies to all that have dental insurance:

Our office is happy to assist you in claiming any orthodontic benefits covered by your dental insurance program. In order for the benefits to arrive as soon as possible, the following details need to be carried out:

First, inform us at your first visit which orthodontic insurance coverage you have. This will permit the most efficient and accurate presentation of the pre-treatment and active orthodontic treatment fees. We ask that you completely fill out the orthodontic insurance information form enclosed with employer, employer's address, employee's social security number, employee's date of birth, and insurance address. This will ensure that claim submission will not be delayed.

Please be advised that all fees are arranged with and are the responsibility of the individual patient or family, not the insurance company. Financial assistance from an insurance plan could terminate at any time for any number of reasons.

The amount of the premiums paid usually dictates the amount of reimbursement by an insurance company. Therefore, there may be a wide range in benefits provided, even by the comprehensive plans. Your insurance plan may not include orthodontics as a benefit. Insurance plans with orthodontic benefits usually cover only a portion of the overall fees.

Pre-authorization or "Acceptance of Claim" may be required by your insurance company. If so, common practice is to submit a claim form stating the fee for active orthodontic treatment and wait for the insurance company to authorize its part of the fees involved, which may delay the start of treatment. If your insurance plan requires a pre-authorization, please let our office know.

All services are charged directly to the patient or whomever is the responsible party. It must be understood that if the insurance company's total payments do not equal the expected benefits, the responsible party will need to make up the difference.

If your insurance coverage changes or if you no longer have insurance, please notify our office. We do not adjust our fee each "Open Season". If you lose or discontinue your orthodontic insurance, you no longer receive the benefits, unless otherwise stated in your policy.

IMPORTANT INSURANCE INFORMATION NOTICE!

Please remember to contact your insurance carrier before your first visit to understand your orthodontic benefits.
Find out what your coverage is and bring the information with you.

THANK YOU

Orthodontic Insurance Information

We ask that you fill out this dental insurance information form completely and accurately. This information is absolutely necessary, and will ensure that claim submission will not be delayed.

Patient name:_____

Relationship to insurance holder:_____ **Sex:** ☐ **M** ☐ **F**

Patient birth Date: _____

Insurance Holder

Name:_____

Address: _____

_____

City: _____ **State**: _____ **Zip Code**:_____

Dental plan ID number & SS#:_____

Date of Birth:_____

Company (Employer):_____

Insurance Name & Address:_____

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_____

Group Number:_____

☐ **I hereby authorize payment of the dental benefits otherwise payable to me directly to Village Orthodontics**

☐ **I authorize release of any information relating to this claim.**

_____

Signature

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc,;
- To your family and close friends involved in your treatment; and/or;
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature on the accompanying page. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your question to this person at our office address.

Thank you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You may refuse to sign this acknowledgement ***

I ____, have received a copy of this office's Notice of Privacy Practices.

____
Patient's Name

____
Signature

____
Date

- -

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and this acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

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