PATIENT INFORMATION – ADULT

Patient Name:___________________________________ D.O.B._______________
Married__ Single___ Divorced__ Widowed __
Address: _____________________________________City:_________________State:____Zip______

Home #: __________________Cell #: ___________________

Email address: ____

Employer: ____

Occupation:____ Work #: ___________________

I prefer to be contacted at/by ____

General Dentist: _________________________________ Date last seen:_________________

PRIMARY DENTAL INSURANCE
Policy Holder's Name: ____DOB: __________________
ID #/Social Security #: ____________________________Group #: ____________________________
Employer: ____
Dental Insurance Plan Name & Address: ____
____
____

I am solely responsible for this account: yes___ no___
If no, please provide name, address and telephone number of responsible party:
____

REFERRAL INFORMATION

Name of person/office referring you to our practice:____

Emergency contact (not living with you) :______________________
Address:____

Phone #:______________________

Signature:________________________________

Date: __________________
www.homefordentalcare.com

NEWTOWN ORTHODONTICS
Home For DENTAL CARE

Dental and Health History

Name____ D.O.B. _____________ Gender M F

First Middle Last

Dental Orthodontic History	Yes	No	Additional Information
Thumb/Finger sucking			
Tongue thrust			
Clenching/Grinding teeth			
Mouth breathing habit, snoring or difficulty in breathing			
Chipped or otherwise injured primary (baby) or permanent teeth			
Difficulty in chewing or jaw opening			
Had periodontal (gum) treatment			
Teeth sensitive to hot or cold			
Speech problems			
Supernumerary (extra) or congenitally missing teeth			
Had prior orthodontic examination or treatment			
Bleeding gums, bad taste or mouth odor			
Periodontal “gum” problems			
Any pain or soreness in the muscles of the face or around the ears			
Aware of any loose, broken or missing restorations (fillings)			
Using any forms of fluoride			
Suffered injuries to your face, mouth, teeth or chin			

Medical History	Yes	No
Abnormal Bleeding		
Hypertension		
ADD or ADHD		
AIDS/HIV		
Any operation		
Artificial Joints/Valves		
Asthma		
Autism		
Cancer		
Congenital Heart Disorder		
Convulsions		
Diabetes		
Epilepsy		
Handicaps/Disabilities		
Heart Murmur		
Hemophilia		
Hepatitis		
Kidney Problems		
Liver Problems		
Mitral Valve Prolapse		
Prosthetics		
Rheumatic Fever		
Scarlet Fever		
Sickle Cell Disease		
Tuberculosis (TB)		

Medical History

Primary Physician____

Phone Number____

Last Visit________________

Current Physical Health is: Good____ Fair____

Poor____Explain____

List medications currently taking

____

Is pre-med required for dental visits (please circle) No Yes

Explain____

Allergies to medications: No _____ Yes ____ Explain______________________

Other allergies No_____ Yes____

Latex____Metals____Nickel____Plastic____other________________________

Authorization

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is my responsibility to inform Newtown Orthodontics of changes in my child’s or my own medical status. I authorize the orthodontic staff to perform the necessary dental and/or orthodontic services on my child (if applicable) or myself as needed.

_______________________________________ _________________________

Patient signature (legal guardian if minor) Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM
Guy Coby D.M.D
Heather Albert D.M.D
Newtown Orthodontics LLC
46 Blacksmith Rd, "Suite Tooth"
Newtown, PA 18940

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: __________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

______________________________	______________________________
Please ***print*** patient name	Parent/Guardian Please ***sign***
______________________________	______________________________
Legal Representative	Description of Authority

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other ______________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ____ ______________________________

Signature of Privacy Officer

Newtown Orthodontic LLC
46 Blacksmith Rd. Suite-Tooth, Newtown, Pa 18940

Consent for the Orthodontic Patient

Fortunately, in orthodontics the complications are infrequent, and when they do occur they are usually of minor consequence. Nevertheless, they should be considered when making the decision to undergo orthodontic treatment.

Cavities and permanent markings, such as white lines or spots on the teeth, can occur if patients do not brush frequently and properly, or if they eat hard, sugary or sticky foods. Regular visits to the family dentist are essential in monitoring the health of teeth. Children, adults, and teenagers may require these visits every to 6 months. Adults should have a periodontal evaluation by their family dentist or periodontist before beginning orthodontic treatment.

A tooth that has been previously injured by a blow or has a large filling may require root canal therapy when it is moved with orthodontic appliances. In some cases, the roots of the teeth may become blunted or shortened during treatment. Usually, this is of no consequence, but on rare occasions it may require curtailin treatment, to avoid loss of a tooth.

Teeth have a tendency to change position after orthodontic treatment. This is usually only a minor change, and faithful wearing of retainers can reduce this tendency. The lower front teeth are a common site for these changes, and you should expect some changes in this area. Occasionally a person who has had a normal growth of the jaw may not continue to do so. If growth becomes uneven, the relationship of the jaws may change. This may require additional treatment or in some cases, surgery. Growth disharmony is a biological process beyond the orthodontist's control. All forms of medical and dental treatment including orthodontics have some risks and limitations.

Lack of signs and symptoms of a tempromandibular joint (TMJ) problem does not indicate conclusively that a problem doesn't exist. A TMJ problem may occu during orthodontic treatment and may or may not be related to the treatment. Such a problem may require additional studies or treatment of referral for these problems. Orthodontic treatment can improve dental causes of TMJ pain, but not in all cases.

There have been few reports of injury to the eyes in patients wearing headgear. These patients were either removing the headgear incorrectly or engaging in strenuous horseplay or competitive activities while wearing the appliance. Patients are advised not to wear their headgear during these times.

Due to the wide variation in the size and shape of teeth achievement of the most ideal result (for example, complete closure of excessive space) may require restorative dental treatment. The most common types of treatment are cosmetic bonding, crown and bridge restorative dental care and/or periodontal therapy. You are encouraged to ask questions regarding dental and medical care adjunctive to orthodontic treatment of those doctors who provide these services.

General medical problems can affect orthodontic treatment. You should keep your orthodontist informed of any changes in you medical health. You should inform your orthodontist of any unusual symptoms or broken or loose appliances, as soon are they are noted.The total time for treatment can be longer than estimated. Lack of bone growth, poor cooperation, broken appliances and missed appointments are important factors which can lengthen treatment and affect th quality of the result. . I also understand that should any of the above conditions threaten the health of this patient, this practice may terminate treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that s/he is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections from insurance companies and will credit any such collections to the patient's account. However, this orthodontic office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If it becomes necessary to refer an outstanding account balance for collection there will be an additional 33% charge. The responsible party agrees that they are responsible for all attorney's fees and costs incurred in the collection of this debt.

The under signer hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make through diagnosis of the patient's needs. I grant permission to you or your assignee to telephone me at home or my work to discuss matters related to my treatment. I give my authorization to transfer any records or radiographs to another provider for treatment of my child. I understand that it is my responsibility advise your office of any changes in the information contained in this form.

_________________________	___________	_____________________	_______________
Signature of patient, or parent	Date	Administrator	Date