New Patient Information

Patient Information

Patient Name: ____ Date of Birth: ___________________
Address: ____ City: ___________________ Zip: ___________
Phone Number: _____________________________________ Other Phone: ____________________________
Email Address: ________________________________ Referred by:___________________________________
Current Dentist: ____________________________________ Phone Number: __________________________
Last Dental Checkup: ________________________________

Insurance Information

Insurance Company: _________________________________ Subscriber Name: _______________________
Policy ID: ____ Group Number: __________________________
Subscriber SSN: _____________________________________ Subscriber DOB: _________________________
Employer: ____

Emergency

Emergency Contact Name: ___________________________ Phone Number: __________________________

<u>COMPLETE THIS SECTION IF PATIENT IS A MINOR</u>

Father's Name: ____ Date of Birth: ____________________
Address: [ ] Same, or: _______________________________ City: ___________________ Zip:____________
Phone Number: ______________________________________
Employer: ____ Phone Number: _______________________

Mother's Name: ____ Date of Birth: ___________________
Address: [ ] Same, or: _______________________________ City: ___________________ Zip:____________
Phone Number: ______________________________________
Employer: ____ Phone Number: _______________________

I hereby authorize payment directly to <u>Marc R. Pana, DDS</u> for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize the use of this signature for your use and disclosure of health information to carry out treatment, payment activities, and health care operations.
Sign:____ **Date:** ______________________________
Signature of Patient (Parent/Guardian signature if patient is a minor)

Orthodontic Health History

Patient's Name: ____

Is patient in good health? [ ] Yes [ ] No
If no, please explain: ____

Is patient under physician's care now? [ ] Yes [ ] No
If no, please explain: ____

Is patient taking any medications? [ ] Yes [ ] No
If yes, please indicate: ____

Is patient taking any substances? [ ] Yes [ ] No
If yes, please indicate: ____

Has patient taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?

[ ] Yes [ ] No

Has the patient ever had a blood transfusion? [ ] Yes [ ] No
If yes, please explain: ____

Is patient pregnant or suspect? [ ] Yes [ ] No
If yes, how far along: ____

Has the patient had any of the illnesses listed below?

Aids ARC	[ ] Yes	[ ] No	Dizzy Spells	[ ] Yes	[ ] No	High/Low Blood Pressure	[ ] Yes	[ ] No
Allergies	[ ] Yes	[ ] No	Epilepsy	[ ] Yes	[ ] No	Kidney Disease	[ ] Yes	[ ] No
Anemia	[ ] Yes	[ ] No	Fainting	[ ] Yes	[ ] No	Liver Problems	[ ] Yes	[ ] No
Angina	[ ] Yes	[ ] No	Fever Blisters	[ ] Yes	[ ] No	Rheumatic Fever	[ ] Yes	[ ] No
Asthma	[ ] Yes	[ ] No	Heart Murmur	[ ] Yes	[ ] No	Sinus Trouble	[ ] Yes	[ ] No
Cold Sores	[ ] Yes	[ ] No	Heart Problem	[ ] Yes	[ ] No	Tuberculosis	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No	Hepatitis	[ ] Yes	[ ] No	Venereal Disease	[ ] Yes	[ ] No
Other: ________________________								

Has patient ever had a reaction to a local anesthetic? [ ] Yes [ ] No
If yes, please explain: ____

Is patient allergic to any medication (like penicillin)? [ ] Yes [ ] No
If yes, please explain: ____

Is patient allergic to metal or latex? [ ] Yes [ ] No
If yes, please explain: ____

Does patient's jaw pop or click when chewing? [ ] Yes [ ] No
Any accidents involving the teeth? [ ] Yes [ ] No
Has patient had any disease, condition, or problem not listed that we should know about?
If yes, please explain: ____

Nail Biting	[ ] Yes	[ ] No	Lip Biting	[ ] Yes	[ ] No
Thumb Sucking	[ ] Yes	[ ] No	Night Grinding	[ ] Yes	[ ] No
Pencil Biting	[ ] Yes	[ ] No	Mouth Breathing	[ ] Yes	[ ] No
Other: __________________________					

Print Name: ____________________________________ Sign: ____

Health History Reviewed By: ____ Date: __________________

Patient Sign and Date Below:

Review 6 Months: ______________________________ Review 12 Months: _______________________________

Review 18 Months: _____________________________ Review 24 Months: _______________________________

Respecting the Privacy of our Patients

We value the trust of our patients and are deeply committed to protecting the privacy of patient information. That is why we only collect and disclose information necessary to provide out patients with quality services. We welcome this opportunity to describe the steps we take to protect our patient's information. Our goal is to ensure that you will fully understand our policies and practices regarding the collection, disclosure and protection of this information. You will receive a copy of our privacy statement at the beginning of our doctor-patient, or at your next visit for established patients. The privacy policies described in this statement apply to our current and former patients. It may be necessary to review and revise our privacy policies, in which case we will provide an updated privacy notice.

Information We Collect: In order to provide high quality services, we must collect and often share information about you and individuals covered under your insurance policy that is not publicly available. We do this to better service patients and process claims in a timely manner. We collect and may share the following types of information about you and your family covered by your policy: 1) Information about the identity of you and individuals covered under your policy, including the names, address, and social security numbers of such individuals. 2) Information we receive from you on applications or other insurance and account forms, such as the claims history or medical history of individuals covered under your policy. 3) Information about your transactions and experiences with us, such as the treatments you received from us, your payment history, account balance, and amounts you paid for your care.

Should we need to verify or obtain additional information about you or individuals covered under your policy, we may contact outside sources, such as agents, brokers, administrators, insurance support organizations, consumer reporting agencies, medical providers and government reporting agencies. Information collected from these outside sources may include information and claims or medical reports. Information obtained from outside sources may be retained by these outside sources and disclosed to other persons, in accordance with applicable laws.

How Such Information Is Used: In many cases, it is necessary to share some or all of the information listed above to help us deliver the best possible services to you and individuals covered under your policy. These disclosures are often necessary to fulfill transactions you have requested and to service the insurance policies that you have applied for and/or purchased. For example, we may share information with your insurance agent or broker, claims adjusters and administrators, claims investigators, and outside companies that perform administrative services on our behalf. We may share information about you and individuals covered under your policy to comply with legal and regulator requirements and for other limited purposes that are required or permitted by law. For example, we may share information about you and individuals covered under your policy to: 1) Process a transaction that you request. 2) Protect against fraud or criminal activity. 3) Report account activity to credit bureaus. 4) Comply with local, state or organizations, insurance support agencies, and law enforcement agencies.

Under no circumstances do we sell or share patient information to any outside party.

Access to and Correction of Individual Information: Individuals covered under your policy may write to us if they have any questions about the information that we may have in our records about them or the identity of those persons to whom their information was disclosed during the two years prior to their request. If they wish, they may review this information in person or receive a copy at a reasonable charge. Individuals covered under your policy can notify us in writing if they believe any information should be corrected, amended, or deleted, and we will review their request. We will either make the requested change or explain why we did not do so. If we do not make the requested change, they may submit a short written statement identifying the disputed information, which will be included in all future disclosures of their information.

Confidentiality and Security of Information: We dedicated significant resources to protect the security of our patient information. We restrict access to customer information to those individuals who need to know that information to provide services to you or individuals covered under your policy. We also maintain physical, electronic, and procedural safeguards to protect patient information, and to guard against its unauthorized use.

____ ________________

Signature **Date**