

## Patient Information

Patient Name \_\_\_\_\_ Male Female  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ email \_\_\_\_\_

If patient is a minor, give legal guardian's name(s) \_\_\_\_\_

Siblings and ages \_\_\_\_\_

Whom may we thank for referring you to our office? Dentist \_\_\_\_\_ Friend/Family \_\_\_\_\_  
Patient of our office \_\_\_\_\_ Advertisement: Radio Yellow Pages Newspaper Other \_\_\_\_\_

## Insurance Information

Do you have: Insurance Orthodontic Benefit (i.e. Mayo Benefit) Flex Plan None

Policy Holder's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ and Address \_\_\_\_\_

Insurance Group Number \_\_\_\_\_ Subscriber ID \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

How Long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_  
Street City State Zip

Email Address (for appointment reminders only) \_\_\_\_\_

Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

## Patient Medical History

- |   |     |    |
|---|-----|----|
| 1. Is the patient in good general health at this time?  | Yes | No |
| 2. Is the patient under the care of a physician at this time?                                       | Yes | No |
| 3. Is the patient taking any medication(s)?   | Yes | No |
| 4. Is the patient allergic to any medications?  | Yes | No |
| 5. Has the patient had tonsils and adenoids removed?  | Yes | No |
| 6. Has the patient ever had serious injuries or been hospitalized?                                  | Yes | No |
| 7. Does the patient have any special problems on listed?  | Yes | No |
| 8. Has the patient ever been advised by a physician to take an antibiotic prior to any dental work? | Yes | No |
| 9. Do you now, or have you ever taken bisphosphonates?  | Yes | No |
- Please discuss any items answered yes:

OFFICE USE ONLY:

DATE \_\_\_\_\_

A B C + - CR: G K P VP + -

## Patient Dental History

Patient's Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have their been any injuries to the face, mouth or teeth? Yes      No  
 If Yes, please explain \_\_\_\_\_

Has the patient had (past or present) any of the following habits:

Thumb or finger sucking	Yes	No
Grinding of teeth at night	Yes	No
Lip Biting	Yes	No
Mouth Breathing	Yes	No

Has an Orthodontist been consulted previously for this patient? Yes      No

Has there been orthodontic treatment for other family members? Yes      No  
 If Yes, treated by Dr. \_\_\_\_\_

Has the patient ever been treated for:

TMJ	Yes	No
Bad Bite	Yes	No
Periodontal Gum Disease	Yes	No

Does the patient have any speech problems? Yes      No

Is the patient concerned or anxious about orthodontic treatment? Yes      No

Please explain any concerns about the appearance of the teeth and anything you would like to change about the smile:  
 \_\_\_\_\_  
 \_\_\_\_\_

## Has the patient ever had any of the following?

Yes	No
Congenital Heart Defect Heart Disease Hearing Impairment Heart Murmur Rheumatic Fever Prosthetic (Artificial) Joint Radiation Therapy Respiratory/Lung Disease High Blood Pressure Low Blood Pressure Hepatitis Tuberculosis Aids or H.I.V Positive Venereal Disease Herpes (oral cold-sores) Blood Disorders Jaw Clicking Jaw Pain Emotional Problems	Inflammatory Rheumatism Arthritis Diabetes Ulcers Stroke Anemia Asthma Epilepsy Glaucoma Fainting Spells Kidney Trouble Liver Disease Psychiatric Treatment Drug Addiction Headaches Earaches Allergies Tonsillitis Other

PLEASE DISCUSS ANY ITEMS ANSWERED YES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Acknowledgment

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. **Overby Orthodontics will not be held responsible for any problems arising out of inadequate information or information not disclosed.** I further understand that where appropriate, credit bureau reports may be obtained. I also understand that orthodontic appointments are often during work and/or school hours.

\_\_\_\_\_  
 Signature of Patient or Patient's Legal Guardian, if a minor

\_\_\_\_\_  
 Date

# OVERBY ORTHODONTICS

## AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail (optional): \_\_\_\_\_

### SECTION B: TO THE PATIENT

**Purpose of Authorization:** By signing this form, you are providing authorization to Overby Orthodontics to post the name and/or photo of patient in common areas of any Overby Orthodontics office. For example, Overby Orthodontics may use the patient name and/or photo to display 'After' photos of patients, academic or sporting news clippings of patients, contest winners, etc.

#### Expiration

This authorization expires when the patient has completed their treatment or 2 years of retention monitoring, whichever is longer.

#### Right to Revoke:

You will have the right to revoke this Authorization at any time by giving us written notice of your revocation submitted to the Privacy Officer, noted below.

### SIGNATURE

I understand that, by signing this Authorization form, I am giving my authorization to your use and disclosure of the patient information only as described above.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

OR

I have read and understand the authorization of patient information described above, but I am opting out and choose **not** to give my authorization.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\*\*\*If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Other Representatives: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

You may obtain a copy of our Privacy Practices or submit a revocation of authorization or consent at any time by contacting:

Contact Person: Office Manager / Privacy Officer

Telephone: 507-437-3269

Fax: 507-437-6490

E-mail: [smiles@overbyorthodontics.com](mailto:smiles@overbyorthodontics.com)

Address: 700 1<sup>st</sup> Avenue SW

Austin, MN 55912

YOUR ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT