

W e l c o m e



John D. Hiester, DDS, MSD

Adult Information Sheet

Today's Date: _____

Patient Information

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Employer: _____

Occupation: _____

Employer Address: _____

Business Phone: _____

Dentist: _____ Phone #: _____

Physician: _____ Phone #: _____

Who may we thank for referring you to our office?

Marital Status: _____

Spouse's Name _____

Date of Birth: _____ Age: _____ Sex: _____

Employer: _____

Occupation: _____

Employer Address: _____

Business Phone: _____

Person Responsible for Account: _____

Social Security #: _____

Name and Ages of Children in Family: _____

Medical History

Has the patient ever been treated for any of the following?

Diabetes	_____	Asthma	_____
Pneumonia	_____	AIDS/HIV	_____
Heart Trouble	_____	Kidney Involvement	_____
Hepatitis	_____	Prolonged Bleeding	_____
Rheumatic Fever	_____	Fainting, Dizziness	_____
Bone Disorder	_____	Nervous Disorder	_____
Headaches	_____	Psychiatry	_____
Endocrine	_____	Genetics	_____
Anemia	_____	Skin Disorders	_____
Epilepsy	_____	Other	_____

Are you in good health? _____

Is there any history of major illness or surgery? _____

Are you now under medical care? _____

Allergies or drug sensitivities? _____

Have tonsils and adenoids been removed? _____ Age? _____

Has patient received a blood transfusion since 1980? _____

Has patient been exposed to the AIDS virus? _____

Current medications? _____

Reason? _____

Are there any problems with the jaw?

Clicking _____ Pain _____ Opening _____ Chewing _____

Has there been any injuries to the face, mouth or teeth?

Explain _____

Mouth breather? _____

While awake or asleep? _____

Have you ever been informed of any missing or extra teeth?

Explain _____

Have you seen another orthodontist? _____

Has any member of the family received orthodontic treatment?

Reason for consultation? _____

Insurance Information

Do you have orthodontic Insurance Coverage? _____

Name of Insurance Co.: _____

Mailing Address: _____

Phone #: _____

Policy Holder: _____ SS #: _____

Employer: _____

I authorize the information to be correct. I understand it is my responsibility to notify American Family Orthodontics of any changes in my health history.

Signature

Date

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this Consent. Our Notice; provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving this office written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that *we may decline to treat you or to continue treating you if you revoke this Consent.*

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature

Date