FOR ADULTS: WELCOME TO OUR PRACTICE

Janice Timothée, DMD
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P. 910.642.4529
www.timotheeorthodontics.com

1. ABOUT YOU

Today's date: _____ Age: _____ DOB: _____

☐ Mr ☐ Mrs ☐ Ms ☐ Dr

Name: _____

First Middle Last

I preferred to be called: _____

Home#: _____ Cell#: _____

Work#: _____

Email: _____

Mailing Address

_____

_____

City State Zip

2. ABOUT YOUR EMPLOYER

Name: _____

Address: _____

_____

How long you have worked there? _____

Occupation: _____

When & where are the best times to reach you? _____

_____

Other family members seen by us: _____

_____

Whom we may THANK for referring you? _____

3. SPOUSE INFORMATION

Name: _____

Employer: _____

WK#: _____ Cell#: _____

4. DENTAL INFORMATION

Previous / Present Dentist: _____

Street: _____

Phone#: _____ Last Visit: _____

5. RESPONSIBLE PARTY (IF NOT YOU)

Name: _____

Billing address : _____

_____

City State Zip

WK#: _____ Home#: _____

Cell#: _____

Email: _____

EMERGENCY CONTACT(OTHER THAN SPOUSE)

Name: _____ Relation: _____

WK#: _____ Home#: _____

Cell#: _____

6. PRIMARY DENTAL INSURANCE

Ins. Name: _____

Ins. address : _____

_____

Insurance Co. Phone #: _____

Group/Policy # : _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage ☐ Yes ☐ No

7. SECONDARY DENTAL INSURANCE

Ins. Name: _____

Ins. address : _____

_____

Insurance Co. Phone #: _____

Group/Policy # : _____

_____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage ☐ Yes ☐ No

8. DENTAL HISTORY

How can we help you with your smile today? _____

Are you currently in pain? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had any serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Have you ever had pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Types of bristles: ☐ Hard ☐ Medium ☐ Soft

9. MEDICAL HISTORY

Do you have a primary physician? ☐ Yes ☐ No

Name: _____

Phone #: _____ Last Visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a doctor? ☐ Yes ☐ No

Explain: _____

Are you taking any prescription drugs? ☐ Yes ☐ No

List: _____

FOR WOMEN ONLY:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week#: _____

Are you nursing? ☐ Yes ☐ No

10. HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Prothesis	☐	☐	History of Scarlet Fever
☐	☐	Heart attack	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Artificial valves
☐	☐	HIV+/AIDS	☐	☐	Heart surgery/pacmkr
☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Mitral valve prolapse
☐	☐	Tuberculosis	☐	☐	Artificial bones / joints
☐	☐	Shingles	☐	☐	Sev./freq. headaches
☐	☐	Fever Blister	☐	☐	Hi / low blood pressure
☐	☐	Birth Defects/Hereditary Problems	☐	☐	Drug / alcohol abuse
☐	☐	Ulcers / colitis	☐	☐	Blood transfusion
☐	☐	Heart murmur	☐	☐	Anemia/Radiation tx
☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Sinus problems	☐	☐	Difficulty Breathing
☐	☐	Other_____			

11. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Erythromycin
☐	☐	Codeine	☐	☐	Tetracycline
☐	☐	Latex	☐	☐	Other:
☐	☐	Penicillin			

Our office Is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

11. I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date:_____

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.

Initials: _____ Date:_____

Doctor 's comments:_____

_____

Medical History Update:

1. Date:_____ Signature:_____

Comments:_____

1. Date:_____ Signature:_____

Comments:_____

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Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____Timothée Orthodontics_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

Practice Name: Timothée Orthodontics

Patient Name: _____

Parent/Guardian Name (if applicable): _____

Address: _____

_____

Phone: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Patient/Parent Signature Date

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed and a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: