Welcome To Our Practice

Thomas Orthodontics

731 E. 700 N. Spanish Fork, UT 84660 (801)423-3030

Patient Information

Last Name _____ First Name _____MI _____

Date of Birth _____/_____/_____ Age _____ Male or Female F/M

Social Security _____

Telephone _____ Work # _____

Other/Cell _____ Text reminders: YES or NO

Email _____

Home/Address _____

Apt # _____ City _____ Zip Code _____

Emergency Contact

Name _____ Relationship _____

Telephone _____ Other _____

Responsible Party

Last Name _____ First Name _____ MI_____

Relationship to Patient _____

Date of Birth _____/_____/_____ Social Security _____

Telephone _____ Work _____Other/Cell _____

Home Address _____Apt # _____

City _____Zip Code _____ Email _____

Employer/Company _____

How were you introduced to our Practice?

____Dentist: Name_____

____Friend/Family: Name_____

____Social Media (i.e. Instagram/Facebook)

____Google/Internet Search

____Drive by

____Other: _____

Please fill out reverse side

Primary Dental Insurance

Insured's Name _____

Date of Birth _____/_____/_____ Social Security _____

Relationship to Patient _____

Insurance Company's Name _____

Address _____

Telephone _____

Group/Policy _____

Is there Orthodontic Coverage: YES or NO

Secondary Dental Insurance

Insured's Name _____

Date of Birth _____/_____/_____ Social Security _____

Relationship to Patient _____

Insurance Company's Name _____

Address _____

Telephone _____

Group/Policy _____

Is there Orthodontic Coverage: YES or NO

General Dentist Information

Dentist _____

Street Address _____

Phone # _____

Last Visit _____

Reasons for your orthodontic visit? _____

Whom may we thank for referring you? _____

Are there other family members seen by us and if so, who? _____

MEDICAL HISTORY

Thomas Orthodontics
731 E. 700 N. Spanish Fork, UT 84660 * Phone (801)423-3030

Today's Date _____

Patient Information

Last Name _____ First Name _____ MI _____

Date of Birth _____/_____/_____

Patient Dental History

1. **Y/N** Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?

2. **Y/N** Do your gums ever bleed?

3. **Y/N** Are you taking fluoridated supplements?

4. **Y/N** Do you brush your teeth daily? How often? _____

5. **Y/N** Do you floss teeth daily? How often? _____

6. **Y/N** Are you using or have you ever used bisphosphonate drugs (Fosamax, Boniva, Actonel, Atelvia or Reclast)?

Medical History

What is your current physical health? Good Fair Poor

Are you currently under the care of a doctor? Yes/No
If yes, please
explain_____

Do you have a personal physician? What is your physician's name and phone number?

_____
____

When was your last visit to the general doctor?
_____

Are you taking any prescription drugs? If yes, please list
_____

Please fill out reverse side

Medical Information: for:
Have you ever been diagnosed or treated Please circle one

1. **Y/N** Protesis
2. **Y/N** Cancer
3. **Y/N** Diabetes
4. **Y/N** Rheumatoid Fever
5. **Y/N** HIV +/AIDS
6. **Y/N** Hemophilia
7. **Y/N** Asthma
8. **Y/N** Hepatitis
9. **Y/N** Tuberculosis
10. **Y/N** Heart Murmur
11. **Y/N** History of Scarlet Fever
12. **Y/N** Congenital Heart Defects
13. **Y/N** Convulsion/Epilepsy
14. **Y/N** Abnormal Bleeding
15. **Y/N** Any Stays in the Hospital
16. **Y/N** Kidney/Liver Problems
17. **Y/N** Difficulty Breathing
18. **Y/N** Hearing Impairment
19. **Y/N** Any Operations
20. **Y/N** Handicaps/Disabilities
21. **Y/N** Allergies to Any Drugs
22. **Y/N** Others: _____

Are you Allergic to Any of the Following?

1. **Y/N** Aspirin
2. **Y/N** Codeine
3. **Y/N** Latex
4. **Y/N** Penicillin
5. **Y/N** Erythromycin
6. **Y/N** Dental Anesthetics
7. **Y/N** Tetracycline
8. **Y/N** Nickel/Metals
9. **Y/N** Others _____

For Women Only:

Y/N Are you pregnant?

Y/N Are you nursing?

If you are a young woman 10-15 years old,

when was your first menstrual cycle? (Circle one)

10 10.5 11 11.5 12 12.5 13 13.5 14 14.5 15

(This is to help us understand when peak growth is occurring)

OFFICE USE ONLY

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

Dr. _____ Date _____

Doctor's comments _____

_____

_____

Thomas Orthodontics

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name:_____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 and completely 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:

Contact Person: Kim Turner
Telephone: (801)423-3030
Address: 731 E. 700 N. Spanish Fork, UT 84660

Release of Information: I authorize the release of information including the diagnosis, records, examination, and treatment rendered to me and claims information. This information may be released to:

Spouse: _____
Other: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. 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, (Patient) _____ 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** _____

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

Personal Representative's Name _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will *no*t affect any action you took in reliance of my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked by Consent.

Signature: _____ Date: _____