

**NEW PATIENT
ADULT HEALTH HISTORY**



**SOUTHERN MINNESOTA
ORTHODONTICS**
D R S . SWANSON, VAUBEL AND HEMANN

Date: _____

Please assist us by completing the following questions:

Patient's Name: _____ Sex: _____ Age: _____ Birthdate: _____
 Patient's Social Security #: _____ Home #: _____
 Address: _____ City: _____ Zip: _____ Cell #: _____
 Email address: _____
 Employed By: _____ Occupation: _____ Work Phone: _____
 Marital Status: Single Married Remarried Separated Divorced Widowed
 Spouse's Name: _____ Occupation: _____ Cell Phone: _____
 Spouse's Social Security #: _____ Referred by: _____
 Employed By: _____
 Person Responsible for Account: Self Spouse Other: _____
 Cell Phone: _____ Home Phone: _____

ORTHODONTIC INSURANCE

Primary **Dental** Insurance Co: _____ Group/Plan #: _____ Orthodontic Coverage: Yes No
 Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
 Subscriber's Name: _____ Subscriber's ID #: _____ Subscriber's Birthdate: _____
 Secondary **Dental** Insurance Co: _____ Group/Plan #: _____ Orthodontic Coverage: Yes No
 Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
 Subscriber's Name: _____ Subscriber's ID #: _____ Subscriber's Birthdate: _____

I understand I am responsible for any balance not covered by insurance.

I authorize payment to be made directly to the

orthodontist who has provided these services. Signature _____ Date _____

DENTAL HISTORY

Patient's Dentist: _____ Date of Last Visit: _____

- Have there been any injuries to the face, mouth or teeth? YES NO
- Have you had or do you presently have any of the following habits?
Thumb or finger sucking Lip biting
Grinding of teeth at night Mouth breathing
NO
- Have you been informed of any missing or extra permanent teeth? YES NO
- Are you aware of sores, lumps or irritated areas in the mouth? YES NO
- Has an orthodontist been consulted previously?
 Name: _____ Date: _____ YES NO
- Have you ever been treated for: Bite problem TMJ Periodontal disease
 If so, by whom? _____ NO
- Do you have any speech problems? YES NO
- Are you frightened or anxious about orthodontic treatment? YES NO
- Are you concerned about the appearance of your teeth? YES NO
- Is there anything you would like to change about your smile?
 If so, what: _____ YES NO
- Reason for consultation: _____
- Has there ever been any orthodontic treatment for any other member of your family? YES NO Spouse (Dr. _____)
 Sons (Dr. _____) Daughters (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)
- Are you satisfied with their results? YES NO (over)

MEDICAL HISTORY

- | | |
|--|------------------------------|
| 1. What is the name of your family physician? | Date of last physical: _____ |
| 2. Is your general health good at this time? | ☐ YES ☐ NO |
| 3. Are you under the care of a physician at this time?
Explain: _____ | ☐ YES ☐ NO |
| 4. Are you taking any medications?
Name: _____ | ☐ YES ☐ NO |
| 5. Are you allergic to any medication?
Name: _____ | ☐ YES ☐ NO |
| 6. Have you had your tonsils and adenoids removed? Age: _____ | ☐ YES ☐ NO: |
| 7. Have you ever had a serious illness or been hospitalized?
Explain: _____ | ☐ YES ☐ NO |
| 8. Do you have any special problems not listed?
Explain: _____ | ☐ YES ☐ NO |
| 9. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments?
If yes, antibiotic name and method: _____ | ☐ YES ☐ NO |
| 10. Do you use tobacco? | ☐ YES ☐ NO |
| 11. WOMEN:
Are you pregnant or considering pregnancy during the next 2 years? | ☐ YES ☐ NO |

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

YES NO

- Endocarditis
- Heart Condition
- Heart Pacemaker
- Heart Angina
- Heart Attack (coronary)
- Mitral Valve Prolapse
- Congenital Heart Disease
- Artificial Heart Valve
- Heart Surgery/Date _____
- Heart Murmur
- Rheumatic Fever
- Prosthetic (artificial) Joint
- X-Ray/Radiation (cancer) Therapy
- Respiratory Lung Disease
- High Blood Pressure
- Low Blood Pressure
- Hepatitis

YES NO

- Tuberculosis
- AIDS or H.I.V. Positive
- Venereal Disease
- Herpes (oral-cold sores)
- Blood Disorder
- Inflammatory Rheumatism
- Arthritis
- Diabetes
- Ulcers
- Stroke
- Anemia
- Asthma
- Epilepsy
- Glaucoma
- Fainting Spells
- Kidney Trouble
- Liver Disease

YES NO

- Psychiatric Treatment
- Drug Addiction
- Headaches
- Earaches
- Jaw Clicking
- Allergies
- Jaw Pain
- Tonsillitis
- Emotional Problems
- Snoring
- Sleep Apnea
- Cancer
- Osteoporosis
- Other _____

If Yes is selected please explain: _____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising from inadequate information or information not disclosed. I UNDERSTAND THAT THE VISUAL EXAMINATION IS FREE OF CHARGE, HOWEVER THERE WILL BE A CHARGE FOR ANY DIAGNOSTIC RECORDS DEEMED NECESSARY.

Signature of patient

Signature of Orthodontist

Today's Date _____
Update _____ Initial _____
Update _____ Initial _____
Update _____ Initial _____

NOTES:

SOUTHERN MINNESOTA ORTHODONTICS, P.A. CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

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 Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting.

Contact Person: Allison Schmidt
Telephone: 507-388-2989 Fax: 507-388-2985
Address: 1545 Adams Street, Mankato, MN 56001

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 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: _____

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.

DO NOT SIGN BELOW

Unless you are revoking your previously given consent for use and disclosure of health information.

REVOCAION 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 *not* affect any action you took in reliance on 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 my Consent.

Signature: _____ Date: _____