ColoradoSmiles ORTHODONTICS

PATIENT INFORMATION

Date _____

Patient's name _____ Male/Female
First Middle Last Nickname

Address _____
Street City Zip

Home Phone _____ Birthday _____ Age _____ SSN _____-_____-_____

Whom may we thank for referring you to our office? _____

School _____ Grade _____

Children/Sibling: Name _____ Birthday _____ Age _____

Name _____ Birthday _____ Age _____ Name _____ Birthday _____ Age _____

Friends seen in our office _____

RESPONSIBLE PARTY INFORMATION

Self/Parent/Guardian _____
First Middle Last

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Cell/Other Phone _____ Email Address _____

Previous Address (if less than 3 years) _____

SSN _____-_____-_____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Spouse/Parent/Guardian/Other _____
First Middle Last

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Cell/Other Phone _____ Email Address _____

Previous Address (if less than 3 years) _____

SSN _____-_____-_____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Person financially responsible for this account: _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Birthday _____

Employer name and address _____

Insured's SSN _____-_____-_____ ID# _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____ Phone _____

Do you have dual coverage? Yes _____ No _____ If yes, please complete the following information below:

Insured's Name _____ Birthday _____

Employer name and address _____

Insured's SSN _____-_____-_____ ID# _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____ Phone _____

EMERGENCY INFORMATION

Emergency Contact _____ Relationship to Patient _____

Address _____
Street City Zip

Phone _____ Email Address _____

The office reserves the right to verify the credit status of potential patients seeking payment terms

Signature: Self/Spouse/Parent/Guardian/Other _____ **Date:** _____

Updates (Date & Initial) _____

Updates (Date & Initial) _____

Updates (Date & Initial) _____

Patient Name _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medications? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia	Anemia
Dizziness	Herpes	Prolonged Bleeding	Arthritis	Epilepsy
High Blood Pressure	Radiation/Chemo	Asthma or Hay Fever	GI Disorders	HIV/AIDs
Rheumatic Fever	Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer	

Any other medical conditions, sensory issues or other special needs that you feel we should be aware of _____

_____

DENTAL HISTORY

Dentist _____ Date of Last Visit _____

Address _____ Phone _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to pressure or temperature? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching or grinding your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Are you aware that some appointments will be during school/work hours? _____
Please list hobbies or interests _____

Female Patients only:

Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize the doctor to perform a complete orthodontic evaluation.

Signature: _____ **Date:** _____

Patient Name _____

PRIVACY POLICY

This policy describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your orthodontic office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (970) 867-9464.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize, such as: other dentists and specialists, imaging facilities, laboratories, and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine health care operations. This means we may send your information to other dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. This includes electronic submission of your information for insurance claim purposes. This also includes contact with you and your family to provide appointment reminders or information about treatment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. Colorado Smiles Orthodontics does not sell patient information to any third party. In certain cases of public health interest we may be required to disclose certain information to local, state, or national health organizations or government agencies.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Colorado Smiles Orthodontics maintains physical, electronic, and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. A complaint in no way will influence your course of treatment with our office.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Colorado Smiles Orthodontics occasionally reviews the privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I have reviewed Colorado Smiles Orthodontics' Privacy Policy and understand that my diagnostic records and my name may be used for educational and promotional purposes.

Signature: _____ **Date:** _____