Dr. Danielle Ardoin Doré

Explore ORTHODONTICS -Discover Your Smile

Health History Form

Patient Information **Date: _____**

Last Name:_____ First:_____ MI:_____ Nickname:_____

Address:_____City:_____State:_____Zip_____

Home Phone (___)_____ Cell Phone (___)_____ Work Phone (___)_____

Date of Birth:_____ Age: _____ Sex: ☐ Male ☐ Female SSN#._____

If Student, Name of School_____ _____ Grade_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer:_____ Address:_____

Email Address:_____ Fax (____)_____

Whom may we thank for referring you? _____

Name of Dentist: _____Date of Last Cleaning:_____

Names and Ages of Other Children/Siblings_____

_____

_____

Parent Information ***(please complete if patient is a minor)***

Father's Name:_____	Mother's Name:_____
Address (if different from patient's)_____	Address (if different from patient's)_____
_____	_____
City_____ ST_____ Zip_____	City_____ ST_____ Zip_____
Home No:_____ Work No_____	Home No:_____ Work No_____
Cell No:_____ Fax_____	Cell No:_____ Fax_____
SSN#_____	SSN#_____
Email_____	Email_____
Employer_____	Employer_____
Address_____	Address_____

Person Responsible For This Account

Name:_____ Relationship to Patient_____

Please notify us if contact information is different than above. Thank you!

We are sorry we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek reimbursement from the other parent. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment for this account.

_____ _____

Date *Signature of Patient or Parent/Guardian if Patient is a Minor*

Primary Orthodontic Insurance

Name of Insured_____ DOB_____ Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____)_____
Address of Insured:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- SECONDARY ORTHODONTIC INSURANCE ---------- IF YES, COMPLETE THE FOLLOWING

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer: _____ Work Phone: (____)_____
Address of Insured:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Medical History

Please check if patient has or has had **Circle if applies**
[Y] [N]

[ ] [ ] Joint swelling _____
[ ] [ ] Arthritis/Rheumatoid arthritis _____
[ ] [ ] Bone disorders/Osteoporosis_____
[ ] [ ] Heart problems/Mitral Valve Prolapse_____ Pre-Med ____
[ ] [ ] Blood disorder/Hemophilia _____
[ ] [ ] Rheumatic trouble _____
[ ] [ ] Thyroid problems _____
[ ] [ ] Diabetes _____
[ ] [ ] Emotional problems _____
[ ] [ ] Brain injury _____
[ ] [ ] Kidney or Liver involvement _____
[ ] [ ] Joint Prosthesis _____
[ ] [ ] Tuberculosis _____
[ ] [ ] Anemia _____
[ ] [ ] Tonsils/Adenoids removed _____
[ ] [ ] Autoimmune disease _____
[ ] [ ] AIDS/HIV_____
[ ] [ ] Frequent sore throats/sinusitis/asthma_____
[ ] [ ] Cancer/Chemotherapy/Radiation_____
[ ] [ ] Epilepsy/ fainting spells_____
[ ] [ ] Stomach problems/GE Reflux _____

Any disease, condition or problem not listed above please explain

_____

_____

Name of Primary Physician:

Dental History

Please check if patient has or has had **Circle if applies**
[Y] [N]

[ ] [ ] Any injury to the face, teeth or mouth?_____
[ ] [ ] Thumb, finger, lip sucking habit?_____
[ ] [ ] Any missing teeth?_____
[ ] [ ] Any difficulty in swallowing or chewing?_____
[ ] [ ] Any speech problems?_____
[ ] [ ] Any ulcers or mouth sores? _____
[ ] [ ] Any pain/clicking when opening/closing your mouth?
[ ] [ ] Any headaches, eye pain or migraines?_____
[ ] [ ] Breathes through mouth regularly?_____
[ ] [ ] Snores when sleeping?_____
[ ] [ ] Any cavities?_____
[ ] [ ] Any periodontal disease?_____
[ ] [ ] Any problems with previous dental work?_____
[ ] [ ] Does the patient visit dentist regularly? _____
[ ] [ ] Where x-rays taken at your last dental exam? _____
[ ] [ ] Has an orthodontist been consulted previously?
Chief concern_____

Patient's attitude toward orthodontic treatment:
[ ] *Very Motivated [ ] Will cooperate if needed [ ] Not motivated*

Any additional information that you think we should know about?

_____

_____

WOMEN: Are you pregnant or nursing? **[Y] [N]** What Month?_____

Allergies: List anything you may be allergic to or have had a reaction to: (Ex, meds, latex, metals, foods...)

List all medications now being taken:

I certify that I have read and understand the above and that the information was given accurately. I will not hold my orthodontist, or any staff member for any errors or omissions that I have made in the completion on this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

Signature of Parent/ Guardian *Date*

HIPAA Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement,

but was unable to do so as *documented below:*

Date_____ Initials_____ Reason _____

Tell us about your child

What name do you liked to be called? _____

What would you like to be when you grow up?_____

What are your hobbies/sports? _____

What is your favorite book or movie? _____

What music do you like to listen to or your favorite performer/s? _____

What is your favorite subject in school?_____

Thank you, we look forward to getting to know you better!

Dr. Dore' and Staff