Fremont-Sandusky Orthodontics
Beautiful smiles, beautiful faces

200 South Wayne Street
Fremont, Ohio 43420
534 Columbus Avenue
Sandusky, Ohio 44870
419/332.1134 Tel.
419/332.7834 Fax

WELCOME

Thank you for selecting Fremont-Sandusky Orthodontics! To help us provide you with the best care, please fill out this Patient Information form, the Patient Health History form and the HIPAA Privacy form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help!

Dental and Medical History

General Dentist _____ Date of last exam__ _____

Have the adenoids or tonsils been removed? __Yes __No

Does your Dentist have specific concerns about your teeth? __Yes __No If Yes, please explain_____

Have you ever broken or chipped a tooth? __Yes __No

Have you ever had pain/tenderness in the jaw joint (TMJ/TMD)? __Yes __No

Does/Did you have any of the following habits? __Clenching/Grinding Teeth __Finger/Thumb Sucking __Nail Biting

__Prolonged Bottle/Pacifier __Mouth Breather __Tongue Thrust __Speech Problems __Chewing/Eating Problems

Have you ever had any extractions? __Yes__No If Yes, did you have any prolonged bleeding following the extractions?__Yes__No

What aspects of orthodontic treatment is your main concern?*(please circle all that apply)* Quality Cost Discomfort Time

Physician _____Phone Number _____

Are you currently under the care of your physician? YES NO If YES, explain _____

History of major illness? YES NO If YES, please describe _____

Any sensitivities or allergies? YES NO If YES, please list _____

Currently taking any medications? YES NO If YES, please list _____

Have you been treated for any of the following? *(Please circle all that apply)*

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	

Patient Information *(confidential)*

Patient's Name_____Nickname_____DOB____/____/____Gender F / M

First Middle Last

Home Address _____ City, State, Zip _____

Best phone to reach you_____Alternative Phone_____

E-mail_____ When confirming appointments please use*(please circle all that apply)*Best Phone / E-mail / Text

If Patient is a student, name of school_____Grade_____

If Patient is a minor, name of Mother_____ Father _____

Legal Guardian_____ Address *(if relevant)*_____

Have we treated another member of your family? YES NO If yes, Name _____

How did you hear about our office? *(please check all that apply)* __Family/Friend __School/Church __Community Event?_____

__Current/Previous Patient __YMCA/Rec. Department __Internet __General Dentist __Dental Hygienist

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient's Name: _____ Telephone:_____

Address:_____

SECTION B: TO THE PATIENT (OR PATIENT'S PARENT/GUARDIAN) – 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. Out Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure 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 our 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: Marie Erchenbrecher-Gonzalez, c/o Arruda Orthodontics
Address: 200 S. Wayne St., Fremont, OH
E-mail: arrudaortho@gmail.com **Telephone: 419-332.1134** **Fax: 419-332-7834**

Right of 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.

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 treatment, payment activities and health care operations.

⇨ Signature: _____ Date: _____

IF THIS CONSENT IS SIGNED BY A PERSON REPRESENTATIVE ON BEHALF OF THE PATIENT, PLEASE COMPLETE THE FOLLOWING:

Personal Representative's Name: _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

⇨ Signature: _____ Date: _____

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: __Individual refused to sign, __Communications barriers prohibited obtaining the acknowledgement, __An emergency situation prevented us from obtaining acknowledgement or __Other *(please specify)* _____

Primary Dental Insurance *(Responsible for Account)*

Insured's Name _____ Relationship to Patient _____

Employer _____ Group Num._ _____

Insurance Company Name _____ Phone Num _____

Insurance Company Address _____

Member ID Num _____ Social Security Num _____ Policyholder's DOB _____

Secondary Dental Insurance

Insured's Name _____ Relationship to Patient_ _____

Employer _____ Group Num _____

Insurance Company Name _____ Phone Num___ _____

Insurance Company Address _____

Member ID Num _____ Social Security Num _____ Policyholder's DOB _____

Responsible Parties

If the patient receives Orthodontic treatment with us, will the cost be split with another Responsible Party? (Circle) Yes / No

If yes, Name & Relationship to patient _____ Phone Number _____
Address _____ Percentage of split (i.e. 50/50) _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during during the period of such orthodontic care to third party payers and/or health practitioners.

_____Date:_____ _____Date:_____

Signature of patient (or parent/legal guardian) Signature of additional parent /legal guardian

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