# NEW PATIENT INFORMATION (ADULT)

Thank you for choosing Discover Orthodontics! Please complete all applicable information.

## 1. PATIENT INFORMATION

**Today's Date:** _____ **Date of Birth:** _____

**Patient's Full Name:** _____

**Address:** _____
Street City / State Zip Code

**Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____

**Email Address:** _____

**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

## 2. EMPLOYMENT / SPOUSE INFORMATION

**Employer:** _____ **Occupation:** _____

**Years Employed:** _____ **Spouse Name:** _____ **Spouse DOB:** _____

**Spouse Employer:** _____ **Spouse Years Employed:** _____

## 3. HOW DID YOU HEAR ABOUT US?

☐ Dentist _____ ☐ Family/Friend _____ ☐ Google ☐ Facebook ☐ Other

## 4. DENTAL INSURANCE INFORMATION

### PRIMARY INSURANCE

**Subscriber / Insured Name:** _____
**Relationship to Patient:** _____
**Insurance Company:** _____
**Member ID:** _____
**Group Number:** _____
**Subscriber DOB:** _____
**Employer:** _____

### SECONDARY INSURANCE (IF APPLICABLE)

**Subscriber / Insured Name:** _____
**Relationship to Patient:** _____
**Insurance Company:** _____
**Member ID:** _____
**Group Number:** _____
**Subscriber DOB:** _____
**Employer:** _____

**Please provide a copy of the front and back of your dental insurance card.**

## 5. EMERGENCY CONTACT

**Name:** _____ **Relationship:** _____

**Phone Number:** _____ **Address:** _____

## 6. PREFERRED COMMUNICATION

☐ Text Message ☐ Phone Call ☐ Email **Preferred Phone:** _____

## 7. PATIENT ACKNOWLEDGEMENT

I certify that the information provided above is complete and accurate to the best of my knowledge.
I understand that it is my responsibility to notify Discover Orthodontics of any changes to this information.

**Patient Signature:** _____ **Date:** _____

Discover ORTHODONTICS

## MEDICAL HISTORY

Date of your last visit with a physician: _____

Please check Yes or No. If your answer is Yes, please provide details.

Yes ☐ No ☐ Are you taking any medication currently? _____

Yes ☐ No ☐ Are you allergic to any medication? _____

Yes ☐ No ☐ Do you have a history of any serious illness? _____

Yes ☐ No ☐ Have you had any surgery or hospitalization? _____

Yes ☐ No ☐ Are you currently under the care of a physician? _____

Yes ☐ No ☐ Have you seen a physician in the past 12 months? If yes, why?

Yes ☐ No ☐ For female patients: Has menstruation begun?

Yes ☐ No ☐ Is there any possibility that you are pregnant?
(Please let us know if there is any change.)

***Please check any of the following medical conditions you have or have had in the past:***

| | | | |
|---|---|---|---|
| ☐ Abnormal bleeding / Hemophilia | ☐ Diabetes | ☐ Hepatitis / Liver problems | ☐ Pneumonia |
| ☐ Anemia | ☐ Fainting / Dizziness | ☐ Herpes | ☐ Prolonged bleeding |
| ☐ Arthritis / Joint problems | ☐ Epilepsy / Seizures | ☐ High blood pressure | ☐ Radiation / Chemotherapy |
| ☐ Asthma or hay fever | ☐ Gastrointestinal disorders | ☐ HIV / AIDS | ☐ Rheumatic fever |
| ☐ Bone disorders | ☐ Heart problems | ☐ Kidney problems | ☐ Tuberculosis |
| ☐ Congenital heart defect | ☐ Heart murmur | ☐ Nervous disorders | ☐ Tumor or Cancer |

Do you have any other medical condition not listed above? If yes, please explain: _____

## DENTAL HISTORY

Date of your last dental visit: _____

**General Dentist:** _____ **Phone:** _____

What is your main concern about your teeth? _____

Yes ☐ No ☐ Do you currently have dental pain?

Yes ☐ No ☐ Have you had any unfavorable reaction to dental treatment?

Yes ☐ No ☐ Have you lost a tooth or have a broken tooth?

Yes ☐ No ☐ Do you have any sores or ulcers in your mouth?

Yes ☐ No ☐ Is any part of your mouth sensitive to temperature?

Yes ☐ No ☐ Is any part of your mouth sensitive to pressure?

Yes ☐ No ☐ Do your gums bleed when brushing?

Yes ☐ No ☐ Do you have a habit of chewing on your fingers, nails or tongue?

Yes ☐ No ☐ Do you use a mouth breathing habit?

Yes ☐ No ☐ Have you had orthodontic treatment before? If yes, when?

Yes ☐ No ☐ Has anyone in your family had orthodontic treatment?

Yes ☐ No ☐ How would you describe your results?

Yes ☐ No ☐ Do your teeth or jaws make noises?

Yes ☐ No ☐ Do your teeth or jaws feel uncomfortable in the morning?

Yes ☐ No ☐ Do you clench or grind your teeth when opening or closing your mouth?

Yes ☐ No ☐ Are you aware of clenching or grinding your teeth?

Yes ☐ No ☐ Do you have frequent headaches or facial pain?

Yes ☐ No ☐ Do you have chronic earaches or ear pain?

Yes ☐ No ☐ Does the patient require additional help to follow instructions?

Yes ☐ No ☐ Do you consider the patient to have special needs?

Parent's status: Mother: _____ Father: _____

Will the patient miss school for appointments?

What is the patient's attitude toward receiving orthodontic treatment?

◯ Wants treatment ◯ Treatment is necessary ◯ Not willing, but accepts ◯ Uncooperative

## BENEFITS AND CONSENT

The benefits of orthodontics include improved appearance, better oral health and improved function. Orthodontics improves the appearance and general function of the teeth. Teeth, gums and jaws are an important part of the body and can respond to treatment. If oral hygiene is inadequate, cavities and gum disease may occur. Discomfort in the joints and roots may occur in a small percentage of cases. Teeth change throughout our lives and dental movement may change after treatment. I have read and understand this paragraph.
I understand and acknowledge that I am financially responsible for services provided, regardless of insurance coverage.
I understand my diagnostic information and name may be used for educational and promotional purposes.
I have honestly answered the above questions and agree to inform this office of changes in my medical or dental history.
I authorize Dr. Matthew Ng and/or Dr. Patricia Tran to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

**Patient Consent for Use and Disclosure of Protected Health Information (HIPPA)**

In this Consent Agreement, the words "you" and "your" refers to the patient, and the words "we", "us" and "our" refer to Dr. Matthew Ng, DMD MSD PA and Dr. Patricia Tran, DDS MSD PA and Discover Orthodontics designated personnel.

With your consent, we may use and disclose Protected Health Information (PHI) for purposes of Treatment, Payment and Health Care Operations (TPHCO).

With your consent, we may call your home or other designated location and leave a message on voice mail or with a family member in reference to any items that assists us in carrying out TPHCO, such as appointment reminders, insurance matters and any issue pertaining to your clinical care, including medical history or treatment progress.

With your consent, we may mail to your home or other designated location any items that will assist us in carrying out TPHCO, such as appointment reminder cards and patient statements.

With your consent, we may e-mail to your home or other designated location any items that assist us in carrying out TPHCO, such as appointment reminder cards and patient statements. You have the right to request that we restrict how we use or disclose your PHI to carry out TPHCO. However, our personnel are not required to agree to your requested restrictions, but if we do, we are bound by this agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out TPHCO.

You may revoke this consent in writing except to the extent that we have already made disclosures in reliance upon your prior consent. Without your consent, we may decline to provide treatment to you, forward insurance claims on your behalf, or provide PHI to sources outside of the practice.

_____

Print Name of Parent or Legal Guardian

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

* You have the right to request and receive a paper copy of the full privacy notice