MEDICAL / DENTAL HISTORY FORM

Patient Name:
Date of Birth:

Billing Party:
Relationship To Patient:______________________

General Dentist/Clinic Name:______________________
Date of last cleaning: ______________________________

Main Concern:____________________________________

How did you learn of Three Rivers Orthodontics?
(Please Circle One)
Dentist Family Insurance Location Web Friend
Other________________

Have you seen an orthodontist or had braces? Yes / No
If yes, when____________________________________

Have we treated any other family members? Yes / No
If yes, who?____________________________________

Past and Current Medical / Dental Conditions

Has the patient been diagnosed or treated for any of the following medical conditions?
(Circle all that apply)

Heart Disease | High or Low Blood Pressure | Asthma | Cancer | Arthritis | Diabetes
Tuberculosis | Epilepsy/Seizures | AIDS/HIV positive | Hepatitis | Osteoporosis
Eating Disorder | Depression/Anxiety | Bleeding Disorder | Bisphosphonate Therapy | Other:______________

Allergies to:
Latex : Yes / No Metals: Yes/No
Medications/Other ______________________

Current Medications (Prescription, Over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY

Antibiotics required prior to dental visits? Yes / No
Reason: ____________________________

Does patient have a persistent thumb or finger habit?
Yes / No

Has the patient been diagnosed or treated for any of the following dental conditions?
(Circle all that apply)

Grinding/Clenching | Jaw Injuries/Surgery | Jaw Joint Pain/Popping | Missing Teeth | Extra Teeth
Gum Disease | Root Canal Therapy | Teeth Sensitivity | Broken Teeth | Other: ________________

RELEASE AND WAIVER

Do you consent to appointment reminder postcards? Yes / No

I authorize release of any information regarding mine or my child's orthodontic treatment to my dental and / or medical insurance company.

Patient / Parent / Guardian Signature ____ Date______________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his / her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in mine or my child's medical or dental health.

Patient / Parent / Guardian Signature ____ Date______________________

Consent to arrange for payment and for sharing of my information

Your privacy is important. If you don't understand this form, ask questions. If you'd like us to consider any special requests, please refer to the Notice of Privacy Practices for contact information. We cannot accept changes to this form.

My consent to sharing (release) of my information

- **For treatment**: I authorize you, as my provider, to share my information with other healthcare professionals and facilities for treatment purposes, such as managing or coordinating my care, and related services.
- **For payment**: I authorize you, as my provider, to share my information with my health plan and others as needed for payment purposes, such as eligibility and coverage determinations, billing, processing claims, coordinating benefits, utilization review, and related functions, including those functions that you, as my provider, are required by my health plan or other third-party payers to perform.
- **To run your organization (health care operations)**: I authorize you, as my provider, to share my information with others to improve the quality of my care and experience, and to manage your business operations. This includes activities such as licensing and accreditation, and evaluating quality.
- **Health plan information:** I authorize my health plans to share my information (about services I have received) with you, as my provider, and with other professionals and facilities from whom I receive healthcare, as needed for treatment, management and coordination of my care, accreditation and quality review/measurement.

My responsibility for payment and assignment of benefits

- I authorize you, as my provider, to bill my health plans (including Medicare/Medicaid and other third party payers), directly on my behalf, so that you will receive direct payment of authorized benefits.
- I agree that it is my responsibility to pay for any items or services not covered by my health plans, such as co-payments, deductibles or co-insurance.

My consent to share my information with external health researchers

Research leads to new and better ways to understand and treat diseases and improve care. Our organization often works with outside health researchers. Any health research involving my information is required to get prior review and approval from an Institutional Review Board (IRB). The IRB is charged with the protection of research subjects and helps ensure research is conducted responsibly. Any published results will not identify specific patients.

Unless I check the box below, I authorize the sharing of my information with external health researchers in accordance with the law.

[ ] I do NOT want to have my information shared with external health researchers.

My signature and acknowledgment

My consent will be valid for ten years from the date I give it. I may revoke my consent to share my information, in writing, at any time. Revoking my consent doesn't apply to information that has already been shared. I understand that some uses and sharing of my information are authorized by law and do not require my consent.

For the purposes of my consent, "provider" means the organizations that are part of HealthPartners (see the list in the Notice of Privacy Practices), and use of my information within this group is permitted and is not a "release" of my information. "My information" means information that identifies me and relates to my health and services received, as explained in more detail in the Notice of Privacy Practices.

My provider's Notice of Privacy Practices has been made available to me. It describes my privacy rights and additional disclosures my provider may make according to law.

Date	Time	Signature of patient/authorized representative X
Patient date of birth		Print Name
If authorized representative, relationship to patient		Reason patient unable to sign