Please fill out this form completely, it is important to your dental care. Our goal is to help you reach and maintain good oral health.

Welcome to the Orthodontist

About You

Today's Date: _____

Name: _____ ☐ M ☐ F
Last First Mi

Birthdate: ____/____/____ Age: _____ SS# : _____

Home Address: _____

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Cell #: (____)_____

Wk #: (____)_____ DL #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

What time is best to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Dentist Name: _____

Previous or Present (Please Circle) Date of last visit? _____

Person Responsible for Account: _____

Spouse Information

His/Her Name: _____

Employer: _____

Wk #: (____)_____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Relative or friend not living with you.

Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

Orthodontic Insurance

PRIMARY

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

SECONDARY

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment that my insurance does not cover, including the deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
SIGNATURE DATE

Continued on Back

Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Ph #: (_____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Y ☐ N

Have you had any metal rods, pins or implants? ☐ Y ☐ N

Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N

Please list each one: _____

Have you ever taken Phen-Fen(Redux or Pondimin)? ☐ Y ☐ N

If so, when? _____

WOMEN: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N Week #: _____

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding/Hemophilia	Y	N	Herpes/Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease/Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack/Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

List any other drugs/material allergies: _____

_____ _____

Dental History

What would you like orthodontics to accomplish?

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you still have wisdom teeth? ☐ Y ☐ N

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? ☐ Y ☐ N

Do you breathe through your mouth? ☐ While Awake ☐ While Asleep

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Do you like your smile? ☐ Y ☐ N

If not, what would you change? _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

SIGNATURE DATE

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Medical History Update

Has there been any change in your health status since your last visit? Y N

If Yes, please explain _____

_____

Has there been any change in your health status since your last visit? Y N

If Yes, please explain _____

_____

_____

Patient Signature Date

Doctor Signature Date

Patient Signature Date

Doctor Signature Date

TruDenta®

HEAD HEALTH HISTORY

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

#	DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)		
1	Have you noticed a change in the way your teeth fit together? » If 'Yes', it is because of ☐ Dental Changes ☐ Trauma ☐ Other	☐ Yes	☐ No
2	Where do you think your teeth hit or fit first? ☐ More on the right ☐ Left ☐ Equal ☐ More on the front ☐ Back ☐ Equal		
3	Do your jaw muscles get tight or sore? » When? ☐ Morning ☐ Evening ☐ After chewing	☐ Yes	☐ No
4	Do you have pain or difficulty opening wide?	☐ Yes	☐ No
5	Are you aware of noises in your jaw joints? ☐ Popping ☐ Clicking ☐ Other » Where? ☐ Right ☐ Left ☐ Both » How long? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
	CAUSES & COMPLICATIONS		
6	Do you grind or clench your teeth? » Do you wear a? ☐ Splint ☐ Night Guard ☐ Retainer	☐ Yes	☐ No
7	Have you had any significant dental treatments? ☐ Orthodontics ☐ Oral surgery / wisdom teeth removal ☐ Long dental appointments ☐ Other	☐ Yes	☐ No
8	Have you been in a car accident, major or minor? » How many? _____ » When was the last accident? ☐ 0-6 Months ☐ 6-12 Months ☐ More than 1 year » Did you see the accident coming? ☐ Yes ☐ No » Did the airbag deploy? ☐ Yes ☐ No	☐ Yes	☐ No
9	Have you had sports injuries and/or trauma to your head & neck? » When? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
10	Do you work at a desk, computer or in a forward head posture position? » Do you have any other postural position problems? _____	☐ Yes	☐ No
11	Problems with sleep? » Insomnia ☐ Yes ☐ No » Sleep Apnea ☐ Yes ☐ No » Sleep Disturbances ☐ Yes ☐ No » Less than 7 hours per night ☐ Yes ☐ No » Other _____		

#	SYMPTOMS
12	Do you experience pain in » Jaw ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Face ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Neck ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Shoulders ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Arms ☐ Right ☐ Left ☐ Both ☐ More than 1 year
13	Do you experience ringing or fullness in your ears? ☐ Yes ☐ No » Which one? ☐ Right ☐ Left ☐ Both
14	How often do you get severe headaches/migraines that makes it difficult to function without treatment or medication? ☐ Occasionally ☐ More than twice a year ☐ More than once a month ☐ More than once a week ☐ Never
15	How often do you get other milder headaches? ☐ Daily ☐ More than 3 per week ☐ More than 2 per month ☐ Other _____
16	Have your headaches changed in the last six months? ☐ About the same ☐ Slight worsening ☐ Same but more frequent ☐ A lot worse Got worse when _____
17	What is your stress level? ☐ Mild ☐ Moderate ☐ Severe
18	Do you have anxiety? ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe
19	Because of pain, headaches or migraines, in the last month: # Of days you could not go to school _____ # Of days you did reduced amount of work _____ # Of days you could not do usual household work/parenting _____ # Of days you missed family or social functions _____
20	When you have pain, headaches or migraines, how does that make you feel? *(Check all that apply)* ☐ **Angry** ☐ **Depressed** ☐ **Tired or exhausted** ☐ **Frustrated** ☐ **Guilty** ☐ **Ashamed** ☐ **Relationship tension** ☐ **Other** _____
	NOTES: _____
	FOR OFFICE USE ONLY Pain/Headache/Migraine Impact Score: MILD MODERATE SEVERE

PATIENT PHOTOGRAPH AND TESTIMONIAL AUTHORIZATION FORM

I hereby give my consent for ***Shawn L. Miller, DMD, Inc.*** to take photographs, slides and/or videotape of *(Print full name of patient)* _____ face, jaw, and teeth. I understand that some of these images may be seen and used by other dental professionals, and these images will become part of the patient record.

If I have provided a written testimonial about my experience with ***Shawn L. Miller, DMD, Inc.***, the testimonial may be used in whole or in part as indicated below.

Please circle "do" or "do not" for each statement, and initial.

I	do	do not	consent to the use of these images in professional articles and presentations.	_____
I	do	do not	consent to the use of these images within the dental practice to be seen only by individuals who walk into the practice.	_____
I	do	do not	consent to the use of these images to promote the dental practice through various media, including but not limited to print advertising, brochures, and the practice web site.	_____

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise, from ***Shawn L. Miller, DMD, Inc.*****.** I hereby release and discharge ***Shawn L. Miller, DMD, Inc.*** from any and all claims and demands arising out of or in connection with the use of my name, photograph, personal testimonial, or other information provided by me, including any and all claims for libel and invasion of privacy.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

_____
Print Patient's or Legal Guardian's/Representative's Name

_____ _____
Patient's or Legal Guardian's/Representative's Signature Date

May 2010

Shawn L. Miller, DMD, Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—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. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures 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 your 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: Shawn L. Miller

Telephone: 714-639-1061 Fax: 714-639-3184

E-mail: info@MillerBraces.com

Address: 1110 East Chapman Avenue, Suite 205, Orange, CA 92866

Right to 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.

SIGNATURE

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 out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).