



Adult Patient Registration

About You

Name e-mail
Mr. Mrs. Ms. Dr. Miss.

First Middle Last

I prefer to be called Sex Male Female
Date of Birth Social Security # - -
Home Address City
State Zip
Marital Status Single Married Divorced Widowed Separated
Phone (Home) () - Cell/Pager () -
Phone (Work) () - Ext.

When and where are best time to reach you?

8:30 – noon noon – 1:30 1:30 – 5:00 5:00 – 7:00 7:00 – 9:00
 Home Work
Driver's License # Occupation

Other family members seen by us

General Dentist Last Visit Date 6 month 6 – 12mn 1-2 yr
 2 – 5 yr > 5 yr Never

Whom may we thank for referring you?

Dentist Yellow Pages News Paper Magazines Televisions Radio Friend Mail Others
Dentist Yellow Pages
Newspaper
Magazines
Articles by Dr. Kurchak Dr.Kurchak's Advertising Orthodontics1.net Advertising Invisalign Suresmile
Other
Television Radio Mail
Friend Other

Dental History

What are the main concern' s that you would like orthodontics to accomplish?

Have you ever had or been evaluated for orthodontic treatment?

Yes No

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

Yes No

Your current dental health is

Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had an injury to your

Mouth Teeth Chin

Do you have any speech problems?

Yes No Type:

Do you generally breathe through your mouth?

Yes No

If yes, please choose While Awake? While Sleep

Do you have any missing or extra permanent teeth? Yes No

Temporomandibular and Facial Pain Questionnaire

Does your jaw make noise so that it bothers you or other?

Yes No

Does your jaw get stuck so that you can' t open freely?

Yes No

Does it hurt when you chew or open wide to take a big bite?

Yes No

Do you have earaches or pain in front of the ears?

Yes No

Do you have pain in the face, cheeks, jaws, throat, or temples?

Yes No

Are you unable to open your mouth as far as you want to?

Yes No

Do you suffer from frequent headaches?

Yes No

Does your jaw feel "tired" after a big meal or dental visit?

Yes No

Are you aware of an uncomfortable or bad bite?

Yes No

Are you aware that you grind your teeth at night?

Yes No

Do you have the habit of clamping or "setting" your teeth?

Yes No

Do you have any jaw symptoms or headaches upon waking in the morning?

Yes No

Do you have to chew only on one side?

Yes No

Have you had a blow to the jaw?

Yes No

Are you a habitual gum-chewer, pipesmoker, or nailbiter?

Yes No

Do you suffer from arthritis or pain in other joints?

Yes No

Do you suffer from a nervous stomach or ulcers?

Yes No

Do you suffer from constipation?colitis?

Yes No

Do you suffer from back or neck pain?

Yes No

Have you had whiplash?

Yes No

Do you suffer from skin problems?

Yes No

Do you have allergies?

Yes No

Are you "double jointed" anyway?

Yes No

Have you received treatment for jaw problems?

Yes No

If Yes who directed the treatment?

What was the treatment?

Bite splint

Yes No

Medication

Yes No

Physical Therapy

Yes No

Occlusal Adjustment

Yes No

Orthodontics

Yes No

Counseling

Yes No

Results

Good Fair Poor N/A

Good Fair Poor N/A

Good Fair Poor N/A

Good Fair Poor N/A

Good Fair Poor N/A

Good Fair Poor N/A

Surgery
Other

Yes No
 Yes No

Good Fair Poor N/A
 Good Fair Poor N/A

Medical History

Do you have a personal physician?

Yes No

Physician' s Name

M.D. D.O.

Phone

()

Date of last visit

<6 month 6-12 mn 1-2 Yr 2-5 Yr >5 Yr Never

Your current physical health is

Good Fair Poor

Are you currently under the care of a physician?

Yes No

Please explain:

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

Yes No

Please list each one:

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

Abnormal Bleeding

Yes No

Anemia/Radiation Treatment

Yes No

Artificial Bones/Joints/Valves

Yes No

Asthma

Yes No

Arthritis

Yes No

Blood Transfusion

Yes No

Cancer/Chemotherapy

Yes No

Colitis

Yes No

Congenital Heart Defect

Yes No

Diabetes

Yes No

Difficulty Breathing

Yes No

Drug/Alcohol Abuse

Yes No

Emphysema

Yes No

Epilepsy/Seizures/Fainting

Yes No

Fever Blisters/Herpes

Yes No

Glaucoma

Yes No

Heart Attack/Stroke

Yes No

Heart Murmur

Yes No

Heart Surgery/Pacemaker

Yes No

Hemophilia

Yes No

Hepatitis

Yes No

High/Low Blood Pressure

Yes No

HIV+ /AIDS

Yes No

Hospitalized for Any Reason

Yes No

Kidney Problems

Yes No

Mitral Valve Prolapse

Yes No

Psychiatric Problems

Yes No

Rheumatic/Scarlet Fever

Yes No

Severe/Frequent Headaches

Yes No

Shingles

Yes No

Sinus Problems

Yes No

Tuberculosis (TB)

Yes No

Ulcers

Yes No

Veneral Disease

Yes No

Yes No

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

Are you allergic to any of the followings?

Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Erythromycin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sulfa Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any Metals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dental Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tetracycline	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Animal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Environmental	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Molds/mildew/mites	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other Antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any Plastics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Grass/ pollen	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list any other drugs/materials that you are allergic to:

Have you been treated by an Allergist? Yes No

For Women : Are you taking birth control pills? Yes No

Are you pregnant? Yes No

If yes?
 Week # _____

Are you nursing? Yes No

Spouse information

Mr. Dr. Mrs. Ms.

	First	Middle	Last
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Birthdate	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer	<input type="text"/>		
WorkPhone	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Cell/Pager	<input type="text"/>
Social security	<input type="text"/>	<input type="text"/>	<input type="text"/>

Responsible Party Information

Self Spouse Other

If other?
 Name _____

Relation _____

First Name _____ Last Name _____

City _____ State _____

Home Address _____ Zip _____

Work Phone _____ Ext. _____

Home Phone _____ Cell/Pager _____

Employer _____ Social Security # _____

Driving License # _____

Employer _____

How Long there _____

**Orthodontic Insurance
Primary**

Dental Coverage Yes No Orthodontic Coverage Yes No
Insurance Co. Name _____
Insurance Co. Address _____ City _____
State _____ Zip _____
Insurance Co. Phone _____
Group # (plan, Local or Policy) _____
Relation _____
Insured Name _____
Insured Birthdate _____
Insured' s Employer _____
Type of Orthodontic insurance Traditional DMO/HMO PPO/PDP Other
Insured' s SocialSecurity# _____

Secondary

Dental Coverage Yes No Orthodontic Coverage Yes No
Insurance Co. Name _____
Insurance Co. Address _____ City _____
State _____ Zip _____
Insurance Co. Phone _____
Group # (plan, Local or Policy) _____
Relation _____
Insured Name _____
Insured Birthdate _____
Insured' s Employer _____
Type of Orthodontic insurance Traditional DMO/HMO PPO/PDP Other
Insured' s SocialSecurity# _____

Emergency Contact

In the event of emergency, is there someone who lives near you that we should contact?

Name

	First	Middle	Last
Mr. <input type="checkbox"/> Dr. <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
WorkPhone	<input type="text"/>	Cell/Pager	<input type="text"/> <input type="text"/> <input type="text"/>
HomePhone	<input type="text"/>		

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 it is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for payment of services rendered. If I assign my insurance benefits to Orthodontics1.net, I understand that I am responsible for paying any co-payment and deductibles that my insurance does not cover. I also understand that if the insurance company does not send payment within 30 days to Orthodontics1.net as anticipated, I am responsible for making this payment.

After I have been informed of treatment recommendations and have accepted the treatment, I authorize the orthodontist and his staff to perform the necessary orthodontic services that I have agreed upon.

Name : _____

Signature : _____ Date : _____

Orthodontist : _____ Date : _____

PRIVACY NOTICE
As Outlined by the American Association of Orthodontists
Mark Kurchak, DDS,MS,PA/Orthodontics1.net

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- ♣ To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- ♣ To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- ♣ To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- ♣ Internally, to all staff members who have any role in your treatment;
- ♣ To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- ♣ To your family and close friends involved in your treatment; and/or,
- ♣ We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- ♣ Request restrictions on the use and disclosure of your protected health information;
- ♣ Request confidential communication of your protected health information;
- ♣ Inspect and obtain copies of your protected health information through asking us;
- ♣ Amend or modify your protected health information in certain circumstances;
- ♣ Receive an accounting of certain disclosures made by us of your protected health information; and,
- ♣ You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- ♣ By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- ♣ To abide by the terms of our Privacy Notice that is currently in effect;
- ♣ To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- ♣ Honor any request by you to restrict the use or disclosure of your protected health information;
- ♣ Amend your protected health information if, for example, it is accurate and complete; or,
- ♣ Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient

Date

PRIVACY CONSENT
As Outlined by the American Association of Orthodontists
Mark Kurchak, DDS,MS,PA/Orthodontics1.net

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office' s privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient' s Signature

Print Name

Date