JAMES WATSON,DDS,PA

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?

		Results
Bite splint	☐ Yes ☐ No	☐ Good ☐ Fair ☐ Poor ☐ N/A
Medication	☐ Yes ☐ No	☐ Good ☐ Fair ☐ Poor ☐ N/A
Physical Therapy	☐ Yes ☐ No	☐ Good ☐ Fair ☐ Poor ☐ N/A
Occlusal Adjustment	☐ Yes ☐ No	☐ Good ☐ Fair ☐ Poor ☐ N/A
Orthodontics	☐ Yes ☐ No	☐ Good ☐ Fair ☐ Poor ☐ N/A
Counseling	☐ Yes ☐ No	☐ Good ☐ Fair ☐ Poor ☐ N/A

Surgery	☐ Yes ☐ No	☐ Good ☐ Fair ☐ Poor ☐ N/A
Other	☐ Yes ☐ No	☐ 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? ☐ Yes ☐ No

Abnormal Bleeding	☐ Yes ☐ No	Heart Murmer	☐ Yes ☐ No
Anemia/Radiation Treatment	☐ Yes ☐ No	Heart Surgery/Pacemaker	☐ Yes ☐ No
Artificial Bones/Joints/Valves	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	High/Low Blood Pressure	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	HIV+/AIDS	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No	Hospitalized for Any Reason	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No
Difficulty Breathing	☐ Yes ☐ No	Rheumatic/Scarlet Fever	☐ Yes ☐ No
Drug/Alcohol Abuse	☐ Yes ☐ No	Severe/Frequent Headaches	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Epilepsy/Seizures/Fainting	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Fever Blisters/Herpes	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Heart Attack/Stroke	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No

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

_____

_____

_____

Are you allergic to any of the followings?

Aspirin	☐ Yes	☐ No	Codeine	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Any Metals	☐ Yes	☐ No	Dental Anesthetics	☐ Yes	☐ No
Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Animal	☐ Yes	☐ No	Environmental	☐ Yes	☐ No
Molds/mildew/mites	☐ Yes	☐ No	Other Antibiotics	☐ Yes	☐ No
Any Plastics	☐ Yes	☐ No	Grass/ pollen	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No	Other	☐ Yes	☐ 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

Birthdate

Employer

WorkPhone Cell/Pager

Social security

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. ☐ Dr. ☐			

WorkPhone

Cell/Pager

HomePhone

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

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

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