SHERMAN &BALHOFF
SPECIALISTS IN ORTHODONTICS

ADULT HEALTH HISTORY

PATIENT INFORMATION

FULL NAME (MS,MRS,MR,DR)

BIRTH DATE | SEX ☐ M ☐ F | SS# __ __ __-__ __-__ __ __ __

ADDRESS | CITY | STATE | ZIP

EMAIL

CELL NUMBER | WORK NUMBER

EMPLOYER | MARITAL STATUS

SPOUSE'S NAME | SPOUSE'S CELL NUMBER

NAMES OF FAMILY MEMBERS TREATED BY OUR PRACTICE

SPECIFIC REASON FOR TODAY'S VISIT

DENTAL HISTORY

PATIENT'S DENTIST | HOW DID YOU HEAR ABOUT US?

PAST ORTHODONTIC TREATMENT ☐ Y ☐ N | ORTHODONTIST

DO YOU HAVE ANY ORAL HABITS? ☐ FINGER/THUMB SUCKING ☐ TONGUE THRUST ☐ CLENCHING ☐ GRINDING ☐ OTHER

HAVE YOU EVER EXPERIENCED OR BEEN TREATED FOR TMJ PAIN? ☐ Y ☐ N

HAVE YOU EXPERIENCED ANY DENTAL TRAUMA? ☐ Y ☐ N

MEDICAL HISTORY

PATIENT'S MEDICAL PHYSICIAN

PRESENTLY UNDER PHYSICIAN'S CARE ☐ Y ☐ N | TREATMENT

CURRENT MEDICATIONS

ALLERGIES & DRUG REACTIONS

ADENOIDS PRESENT ☐ Y ☐ N | TONSILS PRESENT ☐ Y ☐ N

DO YOU EXPERIENCE ANY OF THE FOLLOWING? ☐ MOUTH BREATHING ☐ SNORING ☐ SLEEP APNEA

DO YOU SMOKE? ☐ Y ☐ N

ARE THERE ANY **MEDICAL CONDITIONS** THAT WE SHOULD BE AWARE OF? PLEASE DESCRIBE.

I, THE UNDERSIGNED, HAVE GIVEN THE ABOVE DENTAL AND MEDICAL INFORMATION, HAVE REVIEWED IT AND FIND IT ACCURATE. IF THERE ARE ANY LATER CHANGES TO THE HISTORY RECORD, I WILL SO INFORM THE PRACTICE. I HEREBY AUTHORIZE THE TAKING OF X-RAYS AND OTHER RECORDS FOR AN INITIAL DIAGNOSIS IF NEEDED.

_____

PATIENT SIGNATURE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMONG THE MULPTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
OBTAIN PAYMENT FOR THIRD-PARTY PAYERS.
CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERITIFICATIONS.

I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPTIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I HAVE READ THE FOREGOING IN ITS ENTIRETY & UNDERSTAND ITS TERMS.
PATIENT NAME
PATIENT SIGNATURE

PATIENT'S PRIMARY DENTAL INSURANCE POLICHOLDER

POLICYHOLDER'S NAME		BIRTH DATE
INSURANCE COMPANY	POLICY ID	GROUP NUMBER
RELATION TO PATIENT	SS# __ __ __ - __ __ - __ __ __ __	CELL NUMBER

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY INSURANCE.	**INITIAL**
I UNDERSTAND THAT I MUST UPDATE ANY NEW POLICY INFORMATION & I WILL BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.	**INITIAL**
I AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO SHERMAN AND BALHOFF, APDC.	
SIGNATURE	