

Medical and Dental History



Patient Name	Date
Physician	Date of Last Visit
Address	Phone

Circle Yes or No to the questions asked below: (if yes, please fill in details)

Yes No Are you allergic to any medications? allergic to Nickel or Latex?	Yes No Are you	Name of medication(s) List other allergies:
Yes No Do you have a history of a major illness?	Yes No	Have your tonsils or adenoids been removed?
Yes No Have you had any major operations?	Yes No	Have you ever been involved in a serious accident?

List medications currently taking & dosage:

Circle any of the medical conditions below that you *have had* or *currently have*. **Is medication needed prior to dental procedures?** Y / N

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis /Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation / Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV +/ AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Dental History	
Dentist	Date of Last Visit
Address	Phone
Do you go for regular dental check-ups?	
What concerns you most about your teeth?	
Circle Yes or No to the questions asked below: (if Yes, please fill in details)	
Yes No	Details
Yes No	Are you presently in any dental pain?
Yes No	Have you ever experienced any unfavorable reaction to dentistry?
Yes No	Have you ever lost or chipped any teeth?
Yes No	Have there been any injuries to face, mouth or teeth?
Yes No	Is any part of your mouth sensitive to temperature or pressure?
Yes No	Do your gums bleed when you brush?
Yes No	Do you have any type of thumb or tongue habit? Any other oral habit?
Yes No	Are you a mouth breather?
Yes No	Have you ever seen an orthodontist?
Yes No	Has anyone in your family received orthodontic treatment?
	How did they feel about the result?
	What is your attitude toward receiving orthodontic treatment?
Yes No	Are you aware of your jaw clicking or popping? Any jaw pain?
Yes No	Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
Yes No	Are you aware of clenching your teeth during the day?
Yes No	Have you ever been told that you grind your teeth?
Yes No	Do you have "tension" headaches?
Yes No	Have you ever experienced chronic ringing in your ears?
Yes No	Are you aware that some appointments will be during school/work hours?

Benefits of Orthodontics Aesthetics, Health, and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and swollen gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment.

If insurance benefits are available and there is a balance on the account any and all insurance payments will be applied to the balance. In the event that an insurance payment is received and the account has a \$0 (zero) balance a refund will be issued to the subscriber of the insurance coverage.

I have read and understand the above paragraphs. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in medical or dental history. I have received, read and understand my Health Information (HIPAA) rights.

_____ Patient/Guardian Date _____ 20_____

HIPAA

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights to your health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact: Brenda Cooper in writing in care of Drs. Savastano & Dunn, 2855 W. Hwy 434, Suite 1011, Longwood, FL. 32779, 407-862-1870 or email: bcooper@cflsmiles.com please be sure to enclose the patient and responsible party's names.