

DENTAL HISTORY

General Dentist _____ Date of last visit: _____

What concerns you most about your teeth? _____

What would you like orthodontics to accomplish? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do your gums bleed when you brush? _____ Do you smoke or use tobacco in any form? _____

Have you ever experienced a mouth or chin injury? _____

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

Do you have any habits/problems affecting your mouth or teeth? _____

Do you have any missing or extra permanent teeth? _____

Do you breathe through your mouth while awake? _____ Or asleep? _____

Have you ever experienced an adverse reaction during a medical or dental procedure? _____

Have you ever had an orthodontic evaluation before? _____ When? _____ Where? _____

Other concerns or pertinent information about your dental health or previous treatment that you would like to share with Dr. Berry: _____

MEDICAL HISTORY

Name of primary physician _____ Phone number _____

Are you allergic to any medications? YES NO If yes, please describe: _____

Are you allergic to metals or latex? YES NO If yes, please describe: _____

Are you under physician care? YES NO If yes, please describe: _____

Are you taking birth control? _____ Are you pregnant? _____ Week # _____

Have you ever had any serious illnesses or injuries? _____

Check (✓) yes or no if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease or Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Heart defects | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Bone disorders |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing impairment | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Handicap/disability |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath | <input type="checkbox"/> Y <input type="checkbox"/> N |

Are you currently taking Fosomax or any other type of bisphosphonate drug to treat osteoporosis? _____

Please list all medications you are currently taking:

_____ for condition _____ Prescribing physician: _____
_____ for condition _____ Prescribing physician: _____
_____ for condition _____ Prescribing physician: _____

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 the 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.**

Signature

Date

**Patient Consent to Use and Disclosure Information for Treatment,
Payment Health Care Operations**

I, _____, parent or legal guardian for _____
Adult completing this form **Patient name**

understand that as part of my health care, Dr. L. Ruth Berry, D.M.D., P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the dental professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means which a third party can verify that services billed were actually provided
- A tool or routine operations, such as assessing quality reviewing the competence of staff

I have been provided with a Notice of Patient Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to view Notice prior to signing this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. treatment, payment

I further understand that Dr. L. Ruth Berry, D.M.D., P.A. reserves the right to change her notice and practices, in accordance with the Section 164.520 of the Code of Federal Regulations. Should Dr. L. Ruth Berry, D.M.D., P.A. change her notice, I may request a copy of any revised notice in person (or by U.S. mail, to be sent to the address I've provided).

I wish to have **the following restrictions to the use of disclosure** of my health information:

Please tell us with whom **we may discuss your/patient's treatment**, payment or healthcare operations:

Example: Spouse (name), children (names), other relatives (names) friend or caregivers (names), **dentists (names), other doctors (names):**

Appointment Reminders:

May we leave an appointment reminder message at your home using doctor's/practice name: **Yes () No ()**

May we leave an appointment reminder message at your work using doctor's/practice name: **Yes () No ()**

I understand that as part of treatment, payment, or healthcare operation, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and **ACCEPT / DECLINE** the terms of this consent.

Patient/Guardian Signature

Print name of person signing

Date

If other than patient is signing, are you the legal guardian, custodian or have Power of attorney for this patient, for treatment, payment or other healthcare operations: **Yes () No ()**

FOR OFFICE USE ONLY

() Consent received by _____ Date _____

() Consent refused by patient () Restrictions

() Consent added to patient's record on _____

Dr. L. Ruth Berry D.M.D., P.A.

So that we may provide you with the best possible state of the art orthodontic services available, we feel it is necessary to take photographs. We would appreciate you taking the time to read and sign this consent form.

PHOTOGRAPHIC WAIVER AND CONSENT

I hereby give permission to Dr. L. Ruth Berry, or any staff she may designate, to take photographs for diagnostic purposes and to enhance the dental records. I agree that these photographs will remain the property of Dr. L. Ruth Berry. I further authorize Dr. Berry to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures, if in her judgment dental research, education or science will be benefited by their use. Patient photographs may also be used for illustration purposes when previewing types of esthetic dental treatment with other patients. ***It is specifically understood that in any such publications the patient will not be identified by name.***

Patient Name

Patient Signature*

Date

**** Patients under 18 years old:***

Print name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date