BLOOM & REDDY
BR
ORTHODONTICS

130 Thomas Johnson Dr. , Suite 2
Frederick, MD 21702
Brorthodontics.com

Patient Information Form

Name _____

Age _____ **Date of Birth** _____

Home Address _____

Phone #s (Home) _____ (Cell) _____ (Work) _____

(Email) _____ (All appointment confirmations are sent via email.)

Where and when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/present dentist: _____ Date of last visit : _____

Primary Responsible Party

Responsible Party: _____ M/F

Relation to Patient _____ DOB _____ SS# _____

Address (if different from patient) _____

Cell# _____ Email _____ Employer _____

Insurance Company _____ Phone# _____

Secondary Responsible Party (if applicable)

Responsible Party: _____ M/F

Relation to Patient _____ DOB _____ SS# _____

Address (if different from patient) _____

Cell# _____ Email _____ Employer _____

Insurance Company _____ Phone# _____

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 be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as assessments and physician certifications.

I have been informed by you of your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***Notice of Privacy Practices*** prior to signing this consent. 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 at the address below 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 healthcare operations. I also understand that you are not required to agree to my requested restrictions. If you do agree, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

TURN OVER →

MEDICAL HISTORY

Physician_____ Office # _____

YES	NO		YES	NO	
o	o	AIDS or HIV Infection	o	o	Hepatitis/ Jaundice
o	o	Allergies	o	o	High Blood Pressure
o	o	Anemia	o	o	Joint Replacement/ Implant
o	o	Angina	o	o	Kidney Disease
o	o	Arthritis	o	o	Leukemia
o	o	Asthma	o	o	Liver Disease
o	o	Cancer	o	o	Low Blood Pressure
o	o	Cardiac Pacemaker	o	o	Radiation Therapy
o	o	Chest Pains	o	o	Recent Weight Loss
o	o	Diabetes	o	o	Respiratory Problems
o	o	Easily Winded	o	o	Rheumatic Fever
o	o	Emphysema	o	o	Sexually Transmitted Diseases
o	o	Epilepsy/ Convulsions	o	o	Stomach Trouble
o	o	Fainting/ Seizures	o	o	Stomach Ulcers
o	o	Frequently Tired	o	o	Stroke
o	o	Glaucoma	o	o	Swollen Ankles
o	o	Heart Disease	o	o	Thyroid Problem
o	o	Heart Murmur	o	o	Tuberculosis
o	o	Heart Troubles			

DOCTOR'S COMMENTS

Dr. Initials	Date

Women Only: Are you or do you think you could be pregnant ?_____ Are you nursing?_____ Taking birth control pills?_____

	YES	NO
Are you under medical treatment now?	o	o
Have you been hospitalized for any surgical operation or serious illness?	o	o
Are you taking any medication(s)?	o	o
Do you use tobacco?	o	o
Do you use alcohol?	o	o
Do you use any illegal drugs?	o	o
Are you wearing contact lenses?	o	o

What medications are you taking?

_____

Are you allergic to, or have you had any reactions to:

	YES	NO
Aspirin	o	o
Barbiturates	o	o
Iodine	o	o
Local Anesthetics (I.E. Novocaine, etc.)	o	o
Penicillin or other antibiotics	o	o
Sedatives	o	o
Sulfa Drugs	o	o

Other _____

Latex Allergy Y / N **Nichol Allergy Y / N**

Dental History

Dentist_____ **Office #** _____ **Date of Last Exam** _____

	YES	NO
Do your gums bleed while brushing or flossing?	o	o
Do you have sores or lumps in or near your mouth?	o	o
Do you have frequent headaches?	o	o
Have you ever had any difficult extractions?	o	o
Have you had any orthodontic work?	o	o
Are your teeth sensitive to hot or cold?	o	o
Do you feel pain in any of your teeth?	o	o
Do you clench or grind your teeth?	o	o
Do you have pain in your jaw, ear, or side of face?	o	o

	YES	NO
Do you ever have difficulty in chewing?	o	o
Are your teeth sensitive to sweet or sour liquids or foods?	o	o
Have you had any head, neck, or jaw injuries?	o	o
Do you bite your lips or cheeks frequently?	o	o
Have you had prolonged bleeding following extractions?	o	o
Have you ever been instructed on how to floss?	o	o
Have you ever been instructed on the correct method of brushing your teeth?	o	o

Any other concerns?_____

Signature: I certify that I have read and understand the above information to the best of my knowledge, the above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health or my child's health.

Patient/ Guardian _____ Date _____