


NAHAS AND DONAHUE ORTHODONTICS

Welcome

 ADULT PATIENT INFORMATION
 Please Print (Confidential)

Today's Date _____

Name _____

First

Middle

Last

Nickname

Age ____ Date of Birth ____/____/____ Social Security # _____ Gender ____ M ____ F

Full Home Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

 Person to Contact in Case of Emergency _____ Relationship _____ Phone () _____
 (Not Living at Same Address)

Name of Family Dentist _____ Date of Last Check-up _____

Who can we thank for referring you to our office? _____

Does Patient play any musical instrument? _____ Engage in contact sports? _____

Have you had any previous Othodontic Treatment or Orthodontic Consultations? ____ Yes ____ No

If yes, where and when? _____

SPOUSE INFORMATION

Name _____ Date of Birth ____/____/____ Social Security # _____

Employer _____ Occupation _____ W Phone _____ Cell Phone _____

Have any of your family members been previously treated at our offices? ____ Yes ____ No

Names _____

Patient Medical History

Physician _____ Phone () _____ Date of Last Exam _____

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Is patient under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has patient ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain: _____ | | |
| 3. Is patient taking any medication(s) including non-prescription medicine?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) is patient taking? _____ | | |
| 4. Has patient ever taken Phen-Fen/Redux?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does patient use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does patient use controlled substances?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is patient wearing contact lenses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does patient have or have they had any of the following? | | |

- | | YES | NO |
|------------------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Aids or HIV Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous Disorders | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|------------------------------------|--------------------------|--------------------------|
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis/Ulcer | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Autoimmune Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Prosthesis | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|---|--------------------------|--------------------------|
| 9. Is patient allergic to or have had any reactions to the following? | <input type="checkbox"/> | <input type="checkbox"/> |
| Local anesthetics (e.g. Novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or any Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> |

10. Women Only
- | | | |
|--|--------------------------|--------------------------|
| a. Is patient pregnant or thinking she may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Is patient taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|----------------------------|--------------------------|--------------------------|
| Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily Irritated | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Medical Problems: | | |
| 1. _____ | | |
| 2. _____ | | |

★ DOES THE PATIENT REQUIRE ANTIBIOTICS FOR DENTAL TREATMENT? YES NO

Patient Dental History

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do patients gum bleed while brushing or flossing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does patient feel pain in any teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has patient any sores or lumps in or near mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has patient had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has patient ever experienced any of the following problems in his/her jaw? | | |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does patient have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does patient clench or grind teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does patient bit lips or cheeks frequently?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has patient ever had difficult extractions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has patient ever had prolong bleeding?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has patient ever had any orthodontic treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has patient ever received oral hygiene instructions regarding care of teeth/gums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does patient like their smile?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. What is your chief orthodontic (dental) concern(s)? | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to patient's health. I authorize Nahas & Donahue Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Nahas & Donahue Orthodontics any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of the patient.

X _____
Signature Relationship to Patient Date

Doctors Comments	

Signature	Date

NAHAS AND DONAHUE ORTHODONTICS

GEORGE H. NAHAS, DDS
THOMAS J. DONAHUE, DMD
ORTHODONTIC SPECIALISTS

WELCOME TO OUR OFFICE!

Please take a moment to complete the following so that we can better serve you!

ORTHODONTIC INSURANCE INFORMATION FORM

PRIMARY ORTHODONTIC INSURANCE

Patient Name _____ Patient Birthdate _____
Insurance Holder Name _____
Relationship to Patient _____
Insured Social Security # _____ Insured Holder Birthdate _____
Full Address _____
Employer _____
Home Phone # _____ Business Phone # _____
Insur Co Name _____ Insur Co Phone # _____
Insur Co Full Address _____
Subscriber # _____ Group # _____

ADDITIONAL ORTHODONTIC INSURANCE

Patient Name _____ Patient Birthdate _____
Insurance Holder Name _____
Relationship to Patient _____
Insured Social Security # _____ Insurance Holder Birthdate _____
Full Address _____
Employer _____
Home Phone # _____ Business Phone # _____
Insur Co Name _____ Insur Co Phone # _____
Insur Company Full Address _____
Subscriber # _____ Group # _____

AUTHORIZATION

I authorize my insurance company to pay *Nahas and Donahue Orthodontics* all orthodontic benefits otherwise payable to me for services rendered. I authorize the use of the undersigned signature for all insurance submissions. I authorize *Nahas and Donahue Orthodontics* to release any information necessary to process and secure the payment of benefits. I understand that I am financially responsible for any charges not paid by insurance, including those charges that may be incurred by a change in, or loss of, insurance benefits.

SIGNATURE _____ DATE _____

RELEASE AUTHORIZING USE OF PERSONAL LIKENESS

I, _____ (patient full name), consent to the use of my personal image and likeness including, but not limited to images or video representing and/or depicting the treatment provided to me by Drs. Nahas & Donahue, and the effect thereof, for any lawful use. Drs. Nahas & Donahue deem appropriate, including for treatment, advertising his/her its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational purposes.

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by Drs. Nahas & Donahue during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising promotional or education materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Drs. Nahas & Donahue. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Drs. Nahas & Donahue will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that Drs. Nahas & Donahue cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Drs. Nahas & Donahue may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and any other relevant medical conditions, in describing the treatment rendered to me as depicted in any image or video of me.

I understand that Drs. Nahas & Donahue may not and have not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness.

I have read the foregoing in it's entirety and understand its terms.

Patient / Guardian Signature

Date

Print Guardian Name (if patient is a minor)

Guardian Relationship to Patient

Provider Signature

Date

NAHAS & DONAHUE ORTHODONTICS
GEORGE H. NAHAS, DDS & THOMAS J. DONAHUE, DMD

Notice of Privacy Practices Acknowledgement

By signing this form, you will consent to our use and disclosure of your protected health information (PHI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in treatment directly or indirectly
- To obtain payment for services provided to you through third party payers
- To conduct normal healthcare operations such as quality assessments, etc.

I have received/been offered a copy of the above-named office's Notice of Privacy Practices (NOPP) containing a detailed description of the uses and disclosures of my PHI.

We reserve the right to change our privacy practices as described in our NOPP. If we change our privacy practices, we will issue a revised NOPP, which will contact the changes. Those changes may apply to any of your PHI that we maintain.

I understand that I have the right to revoke this consent at any time by giving us written notice of your revocation submitted to your office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities, and health care operations.

Patient – Print Name

Name of Parent/Guardian & Relationship to Patient

Date

.....
OFFICE USE ONLY

_____ Individual Refused to Sign

Signature of Doctor

Date