NEW PATIENT
ADULT HEALTH HISTORY

SMO
SOUTHERN MINNESOTA
ORTHODONTICS
DRS. SWANSON, VAUBEL AND HEMANN

Date: _____

Please assist us by completing the following questions:

Patient's Name: Sex: Age: Birthdate:

Patient's Social Security #: Home #:

Address: City: Zip: Cell #:

Email address:

Employed By: Occupation: Work Phone:

Marital Status: ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed

Spouse's Name: Occupation: Work Phone:

Spouse's Social Security #: Referred by:

Employed By:

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Other:

Business Phone: Home Phone:

ORTHODONTIC INSURANCE

Primary **Dental** Insurance Co: Group/Plan #: Orthodontic Coverage: ☐Yes ☐No

Insurance Co. Address: City: State: Zip:

Subscriber's Name: Subscriber's ID #: Subscriber's Birthdate:

Secondary **Dental** Insurance Co: Group/Plan #: Orthodontic Coverage: ☐Yes ☐No

Insurance Co. Address: City: State: Zip:

Subscriber's Name: Subscriber's ID #: Subscriber's Birthdate:

I understand I am responsible for any balance not covered by insurance.
I authorize payment to be made directly to the orthodontist who has provided these services. Signature_____Date _____

DENTAL HISTORY

Patient's Dentist: Date of Last Visit:

1. Have there been any injuries to the face, mouth or teeth? ☐YES ☐NO
2. Have you had or do you presently have any of the following habits? ☐Thumb or finger sucking ☐Lip biting ☐NO ☐Grinding of teeth at night ☐Mouth breathing
3. Have you been informed of any missing or extra permanent teeth? ☐YES ☐NO
4. Are you aware of sores, lumps or irritated areas in the mouth? ☐YES ☐NO
5. Has an orthodontist been consulted previously? ☐YES ☐NO
   Name: Date:
6. Have you ever been treated for: ☐Bite problem ☐TMJ ☐Periodontal disease
   If so, by whom? ☐NO
7. Do you have any speech problems? ☐YES ☐NO
8. Are you frightened or anxious about orthodontic treatment? ☐YES ☐NO
9. Are you concerned about the appearance of your teeth? ☐YES ☐NO
10. Is there anything you would like to change about your smile? ☐YES ☐NO
    If so, what:
11. Reason for consultation: _____
12. Has there ever been any orthodontic treatment for any other member of your family? ☐YES ☐NO Spouse (Dr._____)
    Sons (Dr._____) Daughters (Dr._____) Brothers (Dr._____) Sisters (Dr._____)
13. Are you satisfied with their results? ☐YES ☐NO

(over)

MEDICAL HISTORY

1. What is the name of your family physician? Date of last physical:
2. Is your general health good at this time? ☐ YES ☐ NO
3. Are you under the care of a physician at this time? ☐ YES ☐ NO
   Explain:
4. Are you taking any medications? ☐ YES ☐ NO
   Name:
5. Are you allergic to any medication? ☐ YES ☐ NO
   Name:
6. Have you had your tonsils and adenoids removed? Age: ☐ YES ☐ NO:
7. Have you ever had a serious illness or been hospitalized? ☐ YES ☐ NO
   Explain:
8. Do you have any special problems not listed? ☐ YES ☐ NO
   Explain:
9. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments? ☐ YES ☐ NO
   If yes, antibiotic name and method:
10. Do you use tobacco? ☐ YES ☐ NO
11. WOMEN: ☐ YES ☐ NO
    Are you pregnant or considering pregnancy during the next 2 years?

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO	
☐	☐	Endocarditis	☐	☐	Tuberculosis	☐	☐	Psychiatric Treatment
☐	☐	Heart Condition	☐	☐	AIDS or H.I.V. Positive	☐	☐	Drug Addiction
☐	☐	Heart Pacemaker	☐	☐	Venereal Disease	☐	☐	Headaches
☐	☐	Heart Angina	☐	☐	Herpes (oral-cold sores)	☐	☐	Earaches
☐	☐	Heart Attack (coronary)	☐	☐	Blood Disorder	☐	☐	Jaw Clicking
☐	☐	Mitral Valve Prolapse	☐	☐	Inflammatory Rheumatism	☐	☐	Allergies
☐	☐	Congenital Heart Disease	☐	☐	Arthritis	☐	☐	Jaw Pain
☐	☐	Artificial Heart Valve	☐	☐	Diabetes	☐	☐	Tonsillitis
☐	☐	Heart Surgery/Date_____	☐	☐	Ulcers	☐	☐	Emotional Problems
☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐	Snoring
☐	☐	Rheumatic Fever	☐	☐	Anemia	☐	☐	Sleep Apnea
☐	☐	Prosthetic (artificial) Joint	☐	☐	Asthma	☐	☐	Cancer
☐	☐	X-Ray/Radiation (cancer) Therapy	☐	☐	Epilepsy	☐	☐	Osteoporosis
☐	☐	Respiratory Lung Disease	☐	☐	Glaucoma	☐	☐	Other _____
☐	☐	High Blood Pressure	☐	☐	Fainting Spells			
☐	☐	Low Blood Pressure	☐	☐	Kidney Trouble			
☐	☐	Hepatitis	☐	☐	Liver Disease			

If Yes is selected please explain: _____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising from inadequate information or information not disclosed. I UNDERSTAND THAT THE VISUAL EXAMINATION IS FREE OF CHARGE, HOWEVER THERE WILL BE A CHARGE FOR ANY DIAGNOSTIC RECORDS DEEMED NECESSARY.

Signature of patient

_____

Signature of Orthodontist

_____

Today's Date_____

Update_____Initial_____

Update_____Initial_____

Update_____Initial_____

Update_____Initial_____

NOTES:

_____

_____

_____

_____

_____

_____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

SOUTHERN MINNESOTA ORTHODONTICS, P.A.
CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE:_____

SECTION B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting.

Contact Person: Allison Schmidt
Telephone: 507-388-2989 Fax: 507-388-2985
Address: 1545 Adams Street, Mankato, MN 56001

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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 revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:
_____Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:
_____

Relationship to Patient:
_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART.

DO NOT SIGN BELOW

Unless you are revoking your previously given consent for use and disclosure of health information.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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