# Date

# 

# Confidential Patient Information Form – Adult

Name \_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_

Last First Middle initial

Address Own Rent

Street City State Zip

How long at this address \_\_\_\_\_\_\_\_\_ Previous address, if less than 3 yrs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_ Occupation \_ No. Yrs Employed

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_ Occupation \_ No. Yrs Employed

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of General Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Insurance Information

Policy Holder’s Name Date of Birth

Insurance Company Group No. SS#/ID#\_\_\_ \_\_\_\_

Insurance Co. Address Insurance Co. Phone

Policy Holder’s Employer/Group Name\_\_

Do you have dual coverage? No 🞏 Yes 🞏 If yes:

Policy Holder’s Name Date of Birth \_\_\_\_\_\_\_\_\_

Insurance Company Group No. SS#/ID#\_\_\_\_ \_\_\_

Insurance Co. Address Insurance Co. Phone

Policy Holder’s Employer/ Group Name

I understand that where appropriate, credit bureau reports may be obtained.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Updates (date & initial)



**Mark Sundberg, DDS, PLLC**

2702 S. 42nd St., Suite 106

Tacoma, WA 98409

**Health Information Portability and Accountability Act (HIPAA)**

**Consent/Acknowledgement Form**

I hereby give my consent for Pacific Northwest Orthodontics to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I also acknowledge Pacific Northwest Orthodontics Notice of Privacy Practices has been provided to me by Pacific Northwest Orthodontics which describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pacific Northwest Orthodontics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pacific Northwest Orthodontics.

With this consent, Pacific Northwest Orthodontics may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Pacific Northwest Orthodontics may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Pacific Northwest Orthodontics may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pacific Northwest Orthodontics restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Pacific Northwest Orthodontics to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pacific Northwest Orthodontics may decline to provide treatment to me.

Signature of Patient or Parent/ Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Parent or Legal Guardian, if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Mark Sundberg, DDS, PLLC**

2702 So. 42nd Street, Suite 106, Tacoma, WA 98409

**MEDICAL / DENTAL INFORMATION FORM - ADULT**

Patient’s Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_ Sex: Male  Female  Patient prefers to be called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the following questions, mark yes, no, or don’t know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.**

Yes No dk/u Skin disorder?

Yes No dk/u Frequent headaches, colds or sore throats?

Yes No dk/u Eye, ear, nose or throat condition?

Yes No dk/u Hay fever, asthma, sinus trouble or hives?

Yes No dk/u Tonsil or adenoid conditions?

**ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING:**

Yes No dk/u Local anesthetics (Novocaine or Lidocaine)?

Yes No dk/u Aspirin

Yes No dk/u Ibuprofen (Motrin, Advil)?

Yes No dk/u Penicillin or other antibiotics?

Yes No dk/u Sulfa drugs?

Yes No dk/u Codeine or other narcotics?

Yes No dk/u Metals, (jewelry, clothing snaps)?

Yes No dk/u Latex (gloves, balloons)?

Yes No dk/u Vinyl?

Yes No dk/u Acrylic?

Yes No dk/u Other substances? Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No dk/u Is the patient taking medications, nutrient supplements, herbal medications or non-prescription medicines? Please name them:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No dk/u Does the patient currently have or ever had a substance abuse problem?

Yes No dk/u Does the patient smoke or chew tobacco?

Yes No dk/u Operations? Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No dk/u Hospitalized? For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No dk/u Other physical problems? Describe \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No dk/u Being treated by another health care professional? Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other medical problems that we should be aware of ?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT PROFILE**

Yes No dk/u Does patient follow directions well?

Yes No dk/u Does patient brush his/her teeth consistently?

Yes No dk/u Does patient have learning disabilities or need extra help with instructions?

Yes No dk/u Is patient sensitive or self-conscious about his/her teeth?

**MEDICAL HISTORY**

**Now, or in the past, has the patient had:**

Yes No dk/u Birth defects or hereditary problems?

Yes No dk/u Bone fractures, any major accidents?

Yes No dk/u Rheumatoid or arthritic conditions?

Yes No dk/u Endocrine or thyroid problems?

Yes No dk/u Kidney problems?

Yes No dk/u Diabetes?

Yes No dk/u Cancer, tumor, radiation treatment or chemotherapy?

Yes No dk/u Stomach ulcer or hyperactivity?

Yes No dk/u Polio, mononucleosis, tuberculosis, or pneumonia?

Yes No dk/u Problems with the immune system?

Yes No dk/u AIDS / HIV positive?

Yes No dk/u Hepatitis, jaundice, or liver problem?

Yes No dk/u Fainting spells, seizures, epilepsy, or neurological disorder?

Yes No dk/u Mental health disturbance or behavior problems?

Yes No dk/u Vision, hearing, tasting, or speech difficulties?

Yes No dk/u Loss of weight recently, poor appetite?

Yes No dk/u History of eating disorder (Anorexia, Bulimia)?

Yes No dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

Yes No dk/u High or Low blood pressure?

Yes No dk/u Tires easily?

Yes No dk/u Chest pain, shortness of breath or swelling ankles?

Yes No dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, newborn heart defects, heart murmur or rheumatic heart disease)?

Yes No dk/u Any pain or soreness in the muscles of the face or around the ears?

Yes No dk/u Difficulty encountered in chewing or jaw opening?

Yes No dk/u Aware of loose, broken or missing restorations (fillings)?

Yes No dk/u Any teeth irritating cheek, lip, tongue or palate?

Yes No dk/u Concerned about spaced, crooked or protruding teeth?

Yes No dk/u Aware or concerned about under or over developed jaw?

Yes No dk/u “Gum boils”, frequent canker sores or cold sores?

Yes No dk/u Taking any form of Fluoride?

Yes No dk/u Any relative with similar tooth or jaw relationships?

Yes No dk/u Had periodontal (gum) treatment?

Yes No dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Yes No dk/u Any serious trouble associated with any previous dental treatment?

Yes No dk/u Ever had a prior orthodontic examination or treatment?

Yes No dk/u Been under another Dental Specialist’s care?

If yes, name

of Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Yes No dk/u Started teething early, or late?

Yes No dk/u Primary (Baby) teeth removed that were not loose?

Yes No dk/u Permanent or “extra” (supernumerary) teeth removed?

Yes No dk/u Supernumerary (extra) teeth or congenitally missing teeth?

Yes No dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

Yes No dk/u Teeth sensitive to heat or cold; tooth throb or ache?

Yes No dk/u Jaw fractures, cysts or mouth infections?

Yes No dk/u “Dead Teeth” or root canals treated?

Yes No dk/u Bleeding gums, bad taste or mouth odor?

Yes No dk/u Periodontal (gum problems)?

Yes No dk/u Food impaction between teeth?

Yes No dk/u Thumb, finger or sucking habit?

Until what age? \_\_\_\_\_\_\_

Yes No dk/u Abnormal swallowing habit (tongue thrusting)?

Yes No dk/u History of speech problems?

Yes No dk/u Mouth breathing habit, snoring, or difficulty in breathing?

Yes No dk/u Tooth grinding, jaw clenching, clicking or locking?

Yes No dk/u Any pain in jaw or ringing in the ears?

How often do you brush? \_\_\_\_\_\_\_\_\_ times per \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Floss? \_\_\_\_\_\_\_\_\_ times per \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was last check-up/cleaning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have any dental work that needs to be completed? Yes / No

If Yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and understand the above questions. I will not hold the orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes later in the history record or medical/dental status, I will so inform this practice.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Member Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised: 9/18/2013