MEIER ORTHODONTICS

GET YOUR BITE...JUST RIGHT!

Medical Dental History Form (confidential)
ADULTS

Date: _____

Patient's Full Name: _____
Prefers to be called:_____
Birth Date: _____ Gender: _____
Home Address: _____
Cell Phone: _____
Primary Email: _____
Preferred Contact Method (check all that apply): [ ] Call [ ] Text [ ] Email

DENTAL INSURANCE (if applicable – complete all fields)
Primary Policy Holder Name: _____ DOB: _____
Policy Holder Address (if different): _____
Member ID or SSN: _____ Employer: _____
Group #: _____ Insurance Company: _____
Claims Mailing Address: _____
Provider Phone Number: _____

DENTIST INFORMATION
Dentist Name: _____ City/State: _____
Last Exam/Cleaning Date: _____

How did you hear about us? _____

Where Else Have You Seen or Heard about Meier Orthodontics
(Please circle ALL that apply)

Online	Our Community Involvement	Person (please name)
Facebook/Instagram	JTAA – Which Sport?_____	Family Member _____
Google/Yahoo	PBGYAA – Which Sport? _____	Friend_____
YouTube	School Agenda / Homework Folders / Billy Bob /	Other_____
Invisalign Website	Teacher Appreciation Party	
Insurance Website	Silent Auction Donation _____	
	The White Party Charity Event	
	Town of Jupiter Events	

What is your primary concern or reason for seeking an orthodontic consultation?

_____

MEDICAL HISTORY – Please check all that apply:
[ ] Asthma
[ ] Anemia
[ ] Cancer If yes, Are you taking medications, radiation or chemo treatments?_____

[ ] Diabetes (Type:_____ Medication:_____)
[ ] Heart Condition (Explain:_____)
[ ] Heart Murmur
[ ] Epilepsy
[ ] Seizures
[ ] Hepatitis
[ ] Tuberculosis
[ ] Other (please explain): _____
Current Medications: _____
Premedication required before dental procedures? [ ] Yes [ ] No
Allergies (drug, food, environmental): _____
Hospitalized in the last 6 months? [ ] Yes [ ] No If yes, explain: _____

BONE / SKELETAL HEALTH

[ ] Have you been diagnosed with any bone or skeletal conditions?
(e.g., Osteoporsis)
[ ] Are you currently taking any medications for a bone or skeletal condition?
If yes, please explain: _____

LEARNING, BEHAVIORAL, & DEVELOPMENTAL CONDITIONS

[ ] Autism Spectrum Disorder
[ ] ADHD
[ ] Sensory Processing Disorder
[ ] Anxiety or other behavioral health conditions
[ ] Other: _____
[ ] None

DENTAL HISTORY – Please check all that apply:

[ ] Maintains 6-month dental checkups
[ ] Grinds or clenches teeth
[ ] Prior orthodontic consultation
[ ] Prior orthodontic treatment – When and how long? _____
[ ] Told you have gum disease
[ ] Jaw clicks or locks when opening/closing
[ ] Dental treatment recommended by general dentist or specialist that is not yet completed
[ ] Bone loss around teeth
[ ] Diagnosed with gingivitis (red puffy gums, bleeding gums)
[ ] Active tooth decay

Additional Notes or Special Accommodations Needed:

_____

SIGNATURE FOR HEALTH HISTORY

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Patient Signature_____ Date_____

PRINT NAME:_____

HIPPA RELEASE AND WAIVER

(Guide To Patient Privacy Rules Is In Waiting Room)

I consent to the use or disclosure of my protected dental health information by **Meier Orthodontics** for the purpose of diagnosing or providing treatment to me, obtaining payment for my dental health care bills or to conduct dental health care operations of **Meier Orthodontics**. I understand that diagnosis or treatment of me by **Scott F. Meier, D.D.S.,** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected dental health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Meier Orthodontics** is not required to agree to the restrictions that I may request. However, if **Meier Orthodontics** agrees to a restriction that I request, the restriction is binding on **Meier Orthodontics** and **Scott F. Meier, D.D.S.**

I have the right to revoke this consent in writing, at any time, except to the extent that **Scott F. Meier, D.D.S.**, or **Meier Orthodontics** has taken action in reliance on this consent.

My "protected dental health information" means dental health information, including my demographic information, collected from me and created or received by my orthodontist, another dental health care provider, a health plan, my employer or health care clearinghouse. This protected dental health information relates to my past, present or future physical or dental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Meier Orthodontics**'s Notice of Privacy Practices prior to signing this document. The **Meier Orthodontics**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected dental health information that will occur in my treatment, payment of my bills or in the performance of dental health care operations of the **Meier Orthodontics**. The Notice of Privacy Practices for **Meier Orthodontics** is also provided **in the reception area.** This Notice of Privacy Practices also describes my rights and the **Meier Orthodontics**'s duties with respect to my protected dental health information.

Meier Orthodontics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Personal Representative **Date**

PRINT NAME

Consent To Release Protected Health Information

I hereby give consent to Meier Orthodontics to release specific protected health information related to my orthodontic treatment to my designated dentist or dental specialist, as indicated below. The purpose of this disclosure is to ensure a seamless and coordinated approach to my dental care.

Please check the information you consent to share:

☐ Exam Findings and Treatment Plan
☐ Diagnostic Photos and X-rays
☐ Treatment Progress Reports

I acknowledge the importance of ensuring that my dental providers have the relevant and necessary information from my orthodontic treatment, especially in situations where collaboration or mutual decision-making is critical.

Furthermore, I commit to promptly informing Meier Orthodontics should there be any change in my general or specialty dental providers during my orthodontic treatment.

I understand that I have the right to revoke this consent in writing at any time, except to the extent that action based on this consent has already been taken.

General Dentist _____

Dental Specialist_____

Print Patient Name: _____

Patient or Guardian Signature: _____ **Date:** _____