Adult Registration

Pediatric Dentistry &
Orthodontics of Central Iowa
Omega Place, Suite 26 - 8515 Douglas Avenue
Telephone: 278-2333 Des Moines, Iowa 50322

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Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you!

PATIENT INFORMATION

Date ______

Name ______
First Middle Last

Nickname ______

Birthdate ______ Age ______ ❑ M ❑ F

Address ______

City ______ State ______ Zip ______

Previous address (if less than 3 years)

______

Home Phone ______

Work Phone ______ Cell Phone ______

Email ______

SSN ______ Marital Status ❑ S ❑ M ❑ D

Employer ______

Job title ______ Years employed ______

Favorite Sports or Hobbies ______

Emergency Contact ______

Phone # ______ Relation ______

Dentist ______ **Last Visit** ______

Physician ______ **Phone** ______

REFERRAL

Who referred you to our office? ______

❑ Dentist ______

❑ Friend ______

❑ Yellow Pages ______

❑ Other ______

SPOUSE'S INFORMATION

Name ______
First Middle Last

Birthdate ______

Address ______

City ______ State ______ Zip ______

Home Phone ______

Work Phone ______

Employer ______

Job title ______ Years employed ______

SSN ______

INSURANCE INFORMATION

Insured? ❑ Yes ❑ No

Primary Insurance Company ______

Subscriber Name ______

Birthdate ______ SSN ______

Subscriber # ______ Group # ______

Subscriber's Employer ______

Patient's Relationship to Subscriber ______

Secondary Insurance Company ______

Subscriber Name ______

Birthdate ______ SSN ______

Subscriber # ______ Group # ______

Subscriber's Employer ______

Patient's Relationship to Subscriber ______

I authorize the relase of any information necessary to process my insurance claim or to communicate with other doctors who may be involved in the patient's healthcare.

Signature ______ Date

I hereby authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original. I understand I am responsible for any amount not covered by the insurance.

Signature ______ Date

DENTAL HISTORY INFORMATION

In your words, what is the orthodontic problem? ____________________

Have you had any previous orthodontic treatment or consultation? ❑ Yes ❑ No

If so, what work was completed and by whom? ____________________

Has any other family member had orthodontics? ❑ Yes ❑ No ____________________

If so, what work was completed and by whom? ____________________

Were the results acceptable? . . . . ❑ Yes ❑ No

Do you now have or have you ever experienced pain or discomfort in your jaw joint? . . . . ❑ Yes ❑ No

Do you grind your teeth?. . . . . ❑ Yes ❑ No

Do you have any speech problems?. . . . . ❑ Yes ❑ No

Do you have or have you ever had any thumb or finger sucking habits? . . . . ❑ Yes ❑ No

Do you play a musical instrument? . . . . ❑ Yes ❑ No

Do you have or have you ever had any periodontal problems or gum disease, etc.?. . . . . ❑ Yes ❑ No

Have you ever experienced an adverse reaction during a medical or dental procedure?. . . . . ❑ Yes ❑ No

Have you ever received serious trauma or injury to the teeth, face, jaws or head? . . . . ❑ Yes ❑ No

Please describe your attitude toward orthodontic treatment?

❑ Wants treatment ❑ Treatment is necessary ❑ Unwilling, but agrees ❑ Uncooperative

PATIENT'S MEDICAL HISTORY

Do you have or have you ever had: ❑ Diabetes ❑ Heart Murmur ❑ Artificial joints or heart valves

Are you under the care of a physician for a specific condition? ❑ Yes ❑ No

If yes, please describe ____________________

Are you taking any medications? ❑ Yes ❑ No

If yes, please list ____________________

Have you ever taken a biphosphonate medication? (usually used to treat bone disorders e.g. Fosamax, Actonel, Zometa) ❑ Yes ❑ No

Do you have any known allergies or adverse reactions to medications? ❑ Yes ❑ No

If yes, please list ____________________

Do you have any allergy or sensitivity to latex or metals? ❑ Yes ❑ No

If yes, please describe ____________________

For female patients: Are you pregnant? ❑ Yes ❑ No

Please check if you have had any of the following:

❑ AIDS/HIV Positive
❑ Allergies
❑ Asthma or Hayfever
❑ Blood Pressure Problems
❑ Problems with Kidneys
❑ Difficulty Breathing
❑ Endocrine or Growth Problems
❑ Headaches
❑ Problems with Heart
❑ Rheumatic/Scarlet Fever
❑ Tonsilitis
❑ Tuberculosis

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

As you may be aware, a new government regulation titled the "Health Insurance and Portability and Accountability Act" or HIPPA was recently passed and includes new laws regarding the privacy of health information. What was once standard ethicial practice is now federal law, and has resulted in the need for this privacy notice. We are happy to inform you that our office is in compliance with these new federal rules. One example would be that your name and address cannot be sold to anyone for marketing purposes, such as a telemarketer.

Please know that, as always, your diagnosis, treatment plan and financial arrangements are discussed directly with you and that the information is considered a private matter. As is minimally necessary, we may disclose health information to your treating dentist or physician as well as to your insurance company to obtain payment for services we provide you. You also have the right to get copies of your health information, which we can duplicate at your request for a reasonable fee.

Thank you for taking the time to read this notice. Please don't hesitate to contact our office if you have any questions regarding this matter.

Responsible Party Signature ____________________ Date