ADULT PATIENT INFORMATION

Date: _____

GETTING TO KNOW YOU...

Patient Name: _____ Nickname: _____ Birthdate: _____

Home Address: _____ SSN: _____ Sex: ◉ M ○ F

City/State/Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____ Time Employed: _____

Spouse's Name: _____ Nickname: _____ Birthdate: _____

Spouse's Employer: _____ Occupation: _____ Time Employed: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

If current address is less than 3 years, please list your previous address: _____

WHAT ARE YOUR GOALS?

If you could change anything about your smile, what would it be? _____

How long have you wanted this change? _____

What factors have stood in your way? _____

Do you have concerns about undergoing orthodontic treatment? _____

If anyone in your family has had braces with our office previously, or currently, please list their names _____

_____

How did you get referred to or learn about our office? Please check all that apply:

☐ My Dentist	Family Member _____	☐ Reputation
☐ Word of Mouth	Friend _____	☐ Commercial
☐ Printed Advertisement	☐ Google search	☐ Website
☐ Road Sign	☐ Digital Ad/Internet	Other: _____

DENTAL INSURANCE INFORMATION

Policy Holder _____ SSN: _____ Birthdate: _____

Employer: _____ ID# _____ Group# _____

Insurance Company Name: _____ Phone Number _____

Insurance Company Address: _____ City/State/Zip: _____

Is the patient covered by 2 dental policies? If so, please complete the following for secondary:

Policy Holder _____ SSN: _____ Birthdate: _____

Employer: _____ ID# _____ Group# _____

Insurance Company Name: _____ Phone Number _____

Insurance Company Address: _____ City/State/Zip: _____

MEDICAL HISTORY

Are you currently seeing a physician or taking medications? ○ Y ○ N

If yes, what is the diagnosis and what medication are you taking? _____

_____

Are you allergic to any medications? If yes, please list with reaction: _____

_____

Do you have any known allergies to any type of metals? ○ Y ○ N

Do you suffer from frequent headaches? ○ Y ○ N

Have you had any significant injuries to your face and teeth? ○ Y ○ N

If yes, please explain: _____

HAVE YOU HAD OR CURRENTLY HAVE ANY HISTORY OF THE FOLLOWING?

☐ AIDS/HIV	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever
☐ Arthritis	☐ Ear Disorder	☐ Herpes/Oral Cold Sores	☐ Shoulder Pain
☐ Artificial Joint	☐ Fainting/Seizures	☐ High Blood Pressure	☐ Sleep Apnea
☐ Asthma	☐ Frequent Sinus Infections	☐ Joint Swelling	☐ Speech Problems
☐ Blood Disorder	☐ Glaucoma	☐ Liver Ailment	☐ Swollen Glands
☐ Bone Disorder	☐ Heart Murmur	☐ Neck Pain	☐ Tuberculosis
☐ Cancer	☐ Heart Trouble	☐ Psychiatric Treatment	☐ Ulcers

If yes to any of these, please describe: _____

Are there any medical conditions not listed above? ○ Y ○ N

If yes, please describe: _____

Physician Name: _____ Phone: _____ Last Exam Date: _____

DENTAL HISTORY

Dentist Name: _____ Phone: _____ Last Exam Date: _____

Is there any dental treatment to be completed prior to orthodontic treatment? _____

How often do you brush their teeth each day? (Check) ○ Several times ○ Twice ○ Once ○ Less Than Once

How often do you floss your teeth each day? (Check) ○ Several times ○ Twice ○ Once ○ Less Than Once

Have you had or have any of the following habits? (Check all that apply)

☐ Lip Biting ☐ Nail Biting ☐ Thumb/Finger Sucking ☐ Gum Chewing ☐ Ice Chewing

Have you had or have any of the following habits? (Check all that apply)

☐ Ear Aches ☐ Jaw clicking/popping ☐ Jaw Joint Pain ☐ Jaw Locking ☐ Facial Pain

☐ Face Tightness/Sore ☐ Clenching ☐ Grinding ☐ Painful Chewing ☐

Have you consulted with an orthodontist previously? ○ Y ○ N Whom/When? _____

If yes, what was it that caused you to seek another opinion? _____

ADDITIONAL INFORMATION

_____

_____

_____

I certify that the above information is true, and to the best of my knowledge.

Signature _____ Date: _____

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SLEEP ASSESSMENT AND EPWORTH SCALE

Patient Name:_____

Date of Birth: _____ Height: _____ Weight:_____ Age:_____

Please list any medical conditions within the last 5 years (hypertension, diabetes, surgery, etc.)

_____

_____

Check appropriate response:

Have you suffered a heart attack or stroke?	○ Yes	◉ No	When?_____
Do you snore at night?	○ Yes	◉ No	○ Occasionally
Witnessed pauses in breathing while asleep?	○ Yes	◉ No	○ Occasionally
Do you have difficulty falling asleep?	○ Yes	◉ No	○ Occasionally
Do you have difficulty maintaining sleep?	○ Yes	◉ No	○ Occasionally
Experience a restless sensation in legs while lying awake in bed?	○ Yes	◉ No	○ Occasionally
Kicking and twitching movements while asleep?	○ Yes	◉ No	○ Occasionally
Experience excessive daytime tiredness?	○ Yes	◉ No	○ Occasionally
Have you ever awakened feeling paralyzed?	○ Yes	◉ No	○ Occasionally
Experience a sudden loss of strength in your arms or legs?	○ Yes	◉ No	○ Occasionally
If the previous answer is Yes, were these events brought on by a sudden, frightening event or laughter?	○ Yes	◉ No	

Check all that apply:
Do you frequently awaken with:

☐ Dry mouth	☐ Headache	☐ Chest pain	☐ Choking & gasping
☐ Nasal congestion	☐ Heartburn	☐ Excessive sweating	☐ Feeling groggy & un-refreshed

According to the following scale choose the appropriate number value to represent how likely you are to fall asleep during the day in the following situations. Try to be honest as possible. If possible, have your significant other help you fill this out.

0-Never 1-Slight chance 2-Moderate 3-Always

Sitting and reading	○ 0	○ 1	○ 2	◉ 3
Watching T.V.	○ 0	○ 1	○ 2	◉ 3
Sitting inactive in public (movie theater, meeting)	○ 0	○ 1	○ 2	◉ 3
Sitting and talking to someone	○ 0	○ 1	○ 2	◉ 3
Sitting quietly after lunch without alcohol	○ 0	○ 1	○ 2	◉ 3
As a passenger in a car for an hour without a break	○ 0	○ 1	○ 2	◉ 3
Driving a vehicle for 2 or more hours	○ 0	○ 1	○ 2	◉ 3
Lying down to rest in the afternoon when circumstances permit	○ 0	○ 1	○ 2	◉ 3

TOTAL:_____

Patient Signature _____ Date: _____

John F. Monacell, D.D.S., P.C.

Specialist in Adult & Child Orthodontics and Dentofacial Orthopedics

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NOTICE OF PRIVACY PRACTICES (HIPAA)

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e. your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e. to determine the results of cleanings, surgery, etc.)
- To third party payers or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, dates of payment, etc.)
- To certifying, licensing and accrediting bodies (i.e. American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation.
- Internally, to all staff members who have any role in your treatment.
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment.
- To contact you in order to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- To email your x-rays, photos, and treatment plan to your other doctors as needed.
- To leave messages or email you regarding upcoming appointments.

Your Rights Regarding Your Health Information

You may ask us to communicate with you in a confidential manner, ask to see or obtain photocopies of your health information and/or ask us to amend your health information if you feel that it is inaccurate or incomplete.

Acknowledgments and Permissions

Please check all that you are acknowledging and granting permission!

☐ I give permission for my photo to be displayed in this office.

☐ I give permission for my photos, x-rays, study models and other diagnostic, treatment and demographic information to be used for the following purposes: Research, Lectures/Presentations, Publications and Practice Marketing.

☐ I give permission for the office of Dr. John Monacell to contact me on my cell phone, email, or any other phone number that I have listed, regarding my account, appointments, insurance, treatment, etc.

☐ I hereby acknowledge that I have received, read and reviewed a copy of this notice of Privacy Practices, the consent to treatment and office procedures. I authorize use of my signature on and release of information for insurance submissions.

Signature of Responsible Party _____ Date: _____

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