3007B Charlestown Crossing Way
New Albany, IN. 47150

Periago Orthodontics

800 Highlander Point Dr. Suite #200
Floyds Knobs, IN. 47119

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(812) 944-5595

1985 Edsel Lane
Corydon, IN. 47112

About You

Today's Date: ____________

Name: ______________________________
Last First Mi

Birthdate: ___/___/___ Age:_____ M ☐ F ☐

Home Address: ______________________________

____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)__________ Cell #: (____) __________

Wk #: (____)______________________________

E-mail Address:______________________________

Employer: ______________________________

Employer's Address:______________________________

____
City State Zip

How long there? ________ Occupation: ____________

What time is best to reach you? ____________

Whom may we thank for referring you? ____________

Other family members seen by us:____________

Dentist Name: ______________________________

Date of last visit? ______________________________

Person Responsible for Account: ____________

Orthodontic Insurance

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name:______________________________

Insurance Co. Address:______________________________

____
City State Zip

Insurance Co. Phone #: (____)______________________

Group # (Plan, Local or Policy #):____________

Insured's Name: ____________ Relation:____________

Insured's Birthdate: ___/___/___ Insured's ID #:____________

Insured's Employer:______________________________

Employer's Address:______________________________

____
City State Zip

ORTHODONTIC INFORMATION RELEASE PER **HIPAA**

Patient Name: ______________________________

Date of Birth: ______/______/______

I authorize the release of information including diagnosis, records, claims and financial information. This information may be released to:

______________________________,

______________________________,

______________________________ &

______________________________.

☐ I do not authorize the release of information to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: ______________________________

Date: ______/______/______

Emergency Contact Information

Name: ______________________________

Employer:______________________________

Wk #: (_____)______________________________

Cell #: (_____)______________________________

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I understand that I am responsible for payment of services rendered and for paying any co-payment that my insurance does not cover, including the deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
SIGNATURE DATE

Continued on Back

Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: ____________________

Ph #: (______) ____________________ Date of last visit: ____________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: ____________________

Do you smoke or use tobacco in any other form? ☐ Y ☐ N

Have you had any metal rods, pins or implants? ☐ Y ☐ N

Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N

Please list each one: ____________________

WOMEN: Are you pregnant? ☐ Y ☐ N

Week #: ____________

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding/Hemophilia	Y	N	Herpes/Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease/Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack/Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

List any other drugs/material allergies: ____________________

____________________ ____________________

Dental History

What would you like orthodontics to accomplish?

____

____

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you still have wisdom teeth? ☐ Y ☐ N

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? ☐ Y ☐ N

Do you breathe through your mouth? ☐ While Awake ☐ While Asleep

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Do you like your smile? ☐ Y ☐ N

If not, what would you change? ____________________

____

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

____________________ ____________
SIGNATURE DATE

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Initials: ____________ Date: ____________

Doctor's Comments: ____________________

____

____

____

____

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

Medical History Update

Has there been any change in your health status since your last visit? Y N

If Yes, please explain ____________________

____

Has there been any change in your health status since your last visit? Y N

If Yes, please explain ____________________

____

____________________ ____________
Patient Signature Date

____________________ ____________
Doctor Signature Date

____________________ ____________
Patient Signature Date

____________________ ____________
Doctor Signature Date