Shine
ORTHO STUDIO

Date: _____

NAME OF PATIENT: _____

How did you hear about our office? _____

Date of birth: _____

Street Address/APT # _____

PO BOX: _____

City, State & Zip: _____

Social Security #: _____
(Only needed for insurance purposes)

Home phone: _____

Cell phone: _____

E-Mail address: _____

Reminder for appt (check all that apply):
___Phone ___Text ___ E-mail____

Occupation: _____
(If a student then not needed)

Employer: _____

Work Phone: _____

Marital Status: Married: ☐ Single: ☐
Divorced: ☐ Widowed: ☐

Spouses name: _____

Children's names and ages:
1.
2.
3.

EMERGENCY CONTACT

Name: _____
Telephone: _____
Relationship: _____

GENERAL PHYSICIAN AND DENTIST INFO:

Physician's name: _____
Physician's Phone #: _____
General DENTIST Name: _____
Dental Office Name: _____
Dental Office Phone #: _____

	YES	NO
Are you now or have you ever taken oral Bisphosphonate medications including Fosamax, Actonel or Boniva?	Y	N
If yes, have you received:		
*Past or current chemotherapy	Y	N
*The intravenous medications	Y	N
Zometa, Aredia or Bonefos	Y	N

To the best of your knowledge, have you ever been diagnosed with:

	YES	NO
Snoring or sleep apnea ----------	Y	N
Chest pains----------	Y	N
Heart Attack/ heart stents----------	Y	N
Mitral Valve Prolapse----------	Y	N
Pacemaker----------	Y	N
Heart Murmur----------	Y	N
Stroke----------	Y	N
Diabetes----------	Y	N
Type 1 Type 2 Last A1C_____		
Rheumatic fever----------	Y	N
Epilepsy/Seizures----------	Y	N
Spina Bifida----------	Y	N
High Blood Pressure----------	Y	N
Asthma----------	Y	N
COPD----------	Y	N
Emphysema----------	Y	N
TB----------	Y	N
Hepatitis----------	Y	N
Prolonged bleeding, healing complications	Y	N
Thyroid Problems----------	Y	N
Glaucoma----------	Y	N
Joint replacement or implant----------	Y	N
If yes, have you ever been told you need a pre-medication before dental procedures? ----------	Y	N
Arthritis----------	Y	N
Acid reflux, eating disorder or severe gag reflex	Y	N
AIDS (HIV)----------	Y	N
Cancer----------	Y	N
If yes, what type_____		
Are you currently being treated	Y	N
Are you pregnant or think you may be pregnant?-	Y	N
Do you smoke or use tobacco----------	Y	N
History of or current drug use----------	Y	N
Difficulty laying back----------	Y	N

Are you or have you ever been allergic to:		
Local anesthetics (Novacaine).-------	Y	N
Penicillin or other antibiotics---------	Y	N
Sedatives (Valium)----------	Y	N
Aspirin----------	Y	N
Ibuprofen----------	Y	N
Tylenol----------	Y	N
Any metals----------	Y	N
Latex----------	Y	N

Any other conditions or allergies you may have?

_____

Do you have routine MRIs or will need an MRI in the next 24 Months? _____ Y N

Please list any medications you are currently taking:_____

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges a copy of the currently effective Notice of Privacy Practices for this healthcare facility is available upon request. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

ARE WE ABLE TO LEAVE A DETAILED MESSAGE IF WE GET A VOICEMAIL?

☐ Yes ☐ No

I AUTHORIZE THIS OFFICE TO POST PICTURES OF MY CHILD OR MYSELF IN AND/OR OUTSIDE OF THE OFFICE, INCLUDING SOCIAL MEDIA SITES IF PERMISSION IS VERBALLY OBTAINED FIRST.

☐ Yes ☐ No

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____

Signature of Privacy Officer_____