



"Brace yourself for a beautiful smile!"

Marlo A. Miller, D.D.S., M.S.
ORTHODONTICS
Board Certified

ADULT PATIENT INFORMATION

Date _____

Patient's name _____
First Middle Last

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Cell Phone _____ Home phone _____ Work phone _____

Email Address _____

Birthdate _____ Social Security # _____

Marital Status: Single Married Widowed Separated Divorced

Employer _____ Occupation _____ No. yrs. employed _____

Spouse's Name _____ Cell Phone _____

Employer _____ Occupation _____ No. yrs. employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Relationship to Patient _____ Birthdate _____

Insurance Company _____ Group No. _____ Member ID/SS # _____

Insurance Phone No. _____ Do you have dual coverage? Yes No If Yes:

Insured's Name _____ Relationship to Patient _____ Birthdate _____

Insurance Company _____ Group No. _____ Member ID/SS # _____

Insurance Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please check Yes or No (If Yes, please fill in details)

- | Yes | No | |
|------------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking any medication? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to any medication? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of a major illness? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any operations? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been involved in a serious accident? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever smoked or chewed tobacco? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have seen a physician in the last 12 months? Why? _____ |
| Female Patients only: | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has menstruation started? _____ |

Please check any of the medical conditions below that you have had or currently have.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Herpes | <input type="checkbox"/> LATEX allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Asthma or Hayfever | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently in any dental pain? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced any unfavorable reaction to dentistry? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have your wisdom teeth been removed? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever lost or chipped any teeth? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have there been any injuries to face, mouth, or teeth? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is any part of your mouth sensitive to temperature? Where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is any part of your mouth sensitive to pressure? Where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed when you brush? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any type of thumb or tongue habit? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a mouth breather? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever seen an orthodontist? If yes, who and when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | What is your attitude toward receiving orthodontic treatment? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has anyone in your family received orthodontic treatment? _____ |
| | | How did they feel about the result? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware of your jaw clicking or popping? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware of clenching your teeth during the day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told that you grind your teeth? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have "tension" headaches? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced chronic ringing in your ears? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware that appointments will be during work hours? _____ |

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Mario Miller to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Marlo A Miller DDS Orthodontics

HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION AND CONSENT/USE OF PHOTOGRAPHS
AND AUDIO AND VIDEO IMAGES

Marlo A Miller DDS Orthodontics respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. Marlo A Miller DDS Orthodontics seeks your permission for your consent to allow us to take and use audio/video/photographic material of you in Marlo A Miller DDS Orthodontics's internal and external communications, including general interest publications and medical and patient education information, marketing, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines).

To ensure that Marlo A Miller DDS Orthodontics is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. Marlo A Miller DDS Orthodontics will keep a copy of your written permission on file.

I do give my permission for Marlo A Miller DDS Orthodontics to use my or my child's name and share details of my or his/her treatment and experience as a patient in communications produced by or on behalf of Marlo A Miller DDS Orthodontics, and consent to take and make use of my and/or my child's audio/ video/photographic images in publications produced by or on behalf of Marlo A Miller DDS Orthodontics. This permission extends both to electronic versions on the Marlo A Miller DDS Orthodontics websites and other internet/electronic applications as well as to printed, filmed, and taped versions.

I do give permission for Marlo A Miller DDS Orthodontics to communicate with me for marketing purposes when they receive payment from a third party to do so.

I am not required to sign this authorization. Marlo A Miller DDS Orthodontics does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or

other form of remuneration as a result of any use of any information and audio/video/photographic material.

I am aware that my protected health information will exist forever in either a recorded, printed, and /or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual 's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Marlo A Miller DDS Orthodontics Privacy Officer at [CLIENT ADDRESS]. I understand that Marlo A Miller DDS Orthodontics, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Marlo A Miller DDS Orthodontics's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: _____

(First)

(m. initial)

(last)

Signature: _____ Date: _____

Address: _____

(Street Address)

(City)

(State)

(zip code)

Phone: _____

(area code) (home or mobile number)

For personal representatives, please provide the following:

I, _____ represent that I am the health care agent/ guardian/ surrogate/ parent of the patient above.

Personal Representative Signature: _____

Dr. Marlo Miller DDS MS Orthodontic Office

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of
Privacy Practices.

Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

