BURTON ORTHODONTICS

Brian J. Burton, DMD, MS, PC

Date: _____

PATIENT INFORMATION

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Birthdate: _____ Sex: _____ Age: _____

Who is your General Dentist?: _____ Grade and School: _____

How did you hear about our office?: _____ Siblings? Name and DOB: _____

Email: _____ _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle Marital Status

Social Security# _____ Relationship to Patient:_____

BirthDate: _____

Please circle: Own/Rent

How long at this address? _____ Home Phone: _____ Work/Cell Phone: _____

Mailing Address (if different from above):_____
Street City State Zip

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ Work/Cell phone:_____
Last First Middle

Employer: _____ Occupation: _____ No. Years Employed: _____

Social Security #_____ Birthdate:_____ Email:_____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ SS or ID#: _____ Birthdate:_____

Insurance Co.: _____ Group #: _____ Telephone#: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Employer: _____

Do you have dual coverage? Yes No If yes:

Insured's Name: _____ SS or ID#: _____ BirthDate: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Employer: _____

DENTAL HISTORY

What are the main goals you would like orthodontics to accomplish?

_____

_____

_____

_____

_____

How many months has it been since your last dental check-up? _____

Have you ever had a negative dental experience? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Have you been evaluated or had orthodontic treatment? Y N

Have you ever injured your face, mouth, teeth or chin? Y N

Have your adenoids or tonsils been removed? Y N

Do you have any missing , extra, or impacted teeth? Y N

Have you ever had any pain or tenderness in your jaw- Y N

joint (TMJ/TMD)? Y N

Do you take any prescriptions or OTC drugs? Y N

If yes, please list each one:_____

_____

_____

Have you ever taken bisphosphonate drugs (Fosamax, Boniva, etc.

used to treat osteoporosis or multiple myeloma)? Y N

HABITS

Did you or do you have any of the following habits?:

Clenching/Grinding teeth	Y	N	Nursing bottle habits	Y	N
Lip sucking/biting	Y	N	Thumb/Finger sucking	Y	N
Mouth breather	Y	N	Tongue Thrust	Y	N
Nail biting	Y	N			

Would you like to discuss finances without child present? Y N

MEDICAL HISTORY

Current Physician? _____

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Have you ever had any of the following medical problems?

Abnormal Bleeding	Y	N	Handicaps/Disabilities	Y	N
Artificial Bones/Joints	Y	N	Hearing impairment	Y	N
Arthritis	Y	N	Heart Problems	Y	N
Asthma	Y	N	Hepatitis	Y	N
Blood Pressure problems	Y	N	HIV+/AIDS	Y	N
Cancer/Chemo/Radiation	Y	N	Kidney/Liver defects	Y	N
Chicken Pox	Y	N	Mitral Valve Prolapse	Y	N
Convulsions/Epilepsy	Y	N	Psychiatric Treatment	Y	N
Diabetes	Y	N	Rheumatic/Scarlet fever	Y	N
Difficulty Breathing	Y	N	Shingles	Y	N
Fainting Spells	Y	N	Sinus Problems	Y	N
Fever Blisters/Cold Sores	Y	N	Tuberculosis	Y	N

For Women : Are you taking birth control pills? Y N

Are you pregnant? Y N

If yes, Week #: _____

Are you nursing? Y N

Are you allergic to any of the following?:

Aspirin	Y	N	Latex	Y	N
Any metals	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Erythromycin	Y	N

Other: _____

_____

Please elaborate on any dental or orthodontic concerns and any additional medical concerns: _____

_____

_____

_____

_____

_____

_____

I hearby state that the information on this form is true and correct to the best of my knowledge and understand that where appropriate, credit bureau reports may be obtained. I agree to allow Dr. Burton to contact my family dentist, physician and other health care professionals as required to permit proper treatment.

Signature (Parent/Guardian if minor): _____ Date: _____

Reviewed by Dr. Burton: _____ Date: _____

PRIVACY NOTICE

Patient name_____

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, home 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 payors 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., the 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; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____

Patient or Responsible Party Date

2640 Patterson Rd.
Grand Junction, CO 81506
970-243-6455