Hugh E. Friel, D.D.S., M.D.S.
Patient Information Form for Adults

Full Name:_____ Nick Name:_____

Age:_____ Birthdate:_____ Social Security #:_____
Single:_____ Married:_____ Divorced:_____ Separated:_____ Widowed:_____

Home Address:_____
Home Phone Number:_____ Cell Phone Number:_____
E-Mail Address:_____

General Dentist:_____ Referred By:_____

Place of Employment:_____ Occupation:_____
Business Address:_____
Business Phone Number:_____

Spouse's Name:_____
Birthdate:_____ Social Security #:_____
Place of Employment:_____
Business Address:_____
Business Phone Number:_____

If you have moved within the last two years, please list previous address:
_____

In case of emergency, please list nearest relative:_____
Phone Number:_____

Names and ages of children in family:_____
_____

Dental Insurance Information

Dental Insurance Carrier & Address:

_____

Insured's Name:_____ ID#:_____ Group#:_____

Dental Insurance Authorization

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_____ Date:_____

Health Questionnaire

1. Do you have regular dental-medical examinations? Yes:_____ No:_____
   Date of last dental appointment:_____
   Date of last dental x-rays:_____
2. Has there been any change in your general health within the past year? If yes, please explain:_____
3. Name of family physician:_____
   Are you currently under treatment, and if so, for what condition?_____
4. Please list any prescription medications you are taking:_____
5. Have you been hospitalized or had any serious illness, and if so, for what condition, illness, or operation?_____
6. Do you have or had any of the following?

Scarlet Fever, Rheumatic Fever/Heart Disease?	Yes	No
Congenital Heart Lesions?	Yes	No
Mitral Valve Prolapse/Heart Murmur?	Yes	No
Allergies to Drugs, Anesthetics, Other?	Yes	No
_____		
Sinus Problems, Hay Fever, Asthma?	Yes	No
Epilepsy, Cerebral of Spastic Condition?	Yes	No
Blood Disorder (Anemia, Hemophilia)?	Yes	No
Herpes?	Yes	No
Hepatitis?	Yes	No
Tuberculosis?	Yes	No
HIV/AIDS?	Yes	No
Latex Allergies?	Yes	No

7. Have you come in contact with someone with Hepatitis, Tuberculosis, or HIV/AIDS? If yes, please specify:_____

8. Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma?
   Yes No
   Have you ever required a blood transfusion? If yes, please explain:
   _____

9. Have you had surgery or x-ray treatment for a tumor, growth, or condition of the mouth, lips? Yes No

10. Are you employed in any situation in which they are exposed regularly to x-rays? Yes No

11. Women: Are you pregnant? Yes No

Dental Questionnaire

1. Please tell us why you think you need to see an orthodontist? _____

_____

2. Have you ever experienced any of the following?

a.	Trouble associated with previous dental treatment	Yes	No
b.	Dental discomfort at this time	Yes	No
c.	Current gum bleeding	Yes	No
d.	Tooth sensitivity to cold, hot, sweets, chewing	Yes	No
e.	Jaw clicking	Yes	No
f.	Pain in or around the ears	Yes	No
g.	Frequent sores in and around the mouth	Yes	No
h.	Fear of dentistry	Yes	No
i.	Had periodontal (gum) treatment	Yes	No
j.	Had orthodontic treatment before	Yes	No
k.	Thumb of finger sucking habits, specify_____	Yes	No

3. Do you breathe through your mouth primarily? Yes No
4. Do you grind or clench your teeth? Yes No
5. Have you ever been told that you have a tongue thrust or reverse swallowing pattern? Yes No
6. Have your tonsils or adenoids been removed? Yes No
   Please indicate:_____
7. Is there any hereditary background which may contribute to this orthodontic pattern? Please specify:_____
8. Hobbies or special interests:_____

Medical and Dental Notes (For Doctor's Use)

Teeth Present	ORTHODONTIC EVALUATION			
	Alignment		**Profile**	
	Transverse		**Sagittal**	
	Vertical			
	Severity:	**Marked**	**Moderate**	**Minimum**
	Ther. Mod:	**Good**	**Fair**	**Poor**
	Motive, Hygiene	**Good**	**Fair**	**Poor**

Remarks:

Privacy Notice

(Health Insurance Portability and Accountability Act of 1996)

Hugh E. Friel DDS and all employees herein are legally required to follow the policies in this notice. We are now legally required to safeguard your protected health information (PHI). PHI includes any information that can be used to identify you. We collect information about your health (past, present, and future), to both provided proper health care and to collect payment for this care.

The following are instances where we may USE AND SHARE YOUR PROTECTED HEALTH INFORMATION:

1. **Treatment:** We may share your PHI with referring dentists, dental specialists, or other health care personnel that are involved in your health care.
2. **To obtain payment for treatment:** We may use your PHI in order to bill or collect payment for the services provided to you. Therefore, it is extremely important that you provide us with up-to-date and accurate PHI
3. **To run our business:** We may share your PHI in order to run our facility according to healthcare regulations.
4. **To business associates:** There are some services, such as our contracted computer software company, that will have access to your PHI. Please note that all business associates are required by our company to protect your PHI through contractual agreements.
5. **Government or law enforcement agency's requests:** We will share your PHI whenever required by law enforcement agencies (to report child abuse, neglect, etc. or in response to court order, subpoena, warrant, etc.)
6. **For Health Oversight Activities:** Activities such as audits investigations, inspections, and licensure are necessary for the government to monitor the health care system and our compliance with your civil rights.
7. **For research:** We may share your PHI with researchers only when an Institutional Review Board (IRB) has approved the research. We will ask for your specific permission to be included in such research.
8. **For appointment reminders and health benefits:** Your name, address, and phone number may be used to contact you as a reminder that you have an appointment.

YOUR RIGHTS REGARDING YOUR PHI

- You have the right to object to information shared with family, friends, or others.
- You have the right to request limits on how we use and share your PHI.
- You have the right to choose how we communicate PHI to you.
- You have the right to see and get copies of your PHI. You must make this request in writing.
- You have the right to get a list of when and to whom we have shared your PHI.
- You have the right to correct, update, or amend your PHI.
    - Please forward all requests for information in writing to:

      HIPAA Officer
      1815 Schadt Ave.
      Whitehall, PA 18052

CHANGES TO THIS NOTICE

We may change the terms of this notice and our privacy policy at any time. Any changes to this policy will be applied to the PHI that we already have. Before making such changes, we will promptly change this notice and post a new notice in our office. You may request a copy of this notice at any time.

I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, THAT IT HAS BEEN FULLY EXPLAINED TO ME, AND THAT I UNDERSTAND ITS CONTENTS:

SIGNTURE OF PATIENT, PARENT, OR GUARDIAN

Informed Consent

For the orthodontic treatment of: _____

In the vast majority of orthodontic cases, significant improvements can be achieved. While a pleasing smile, more balanced face, and healthier bite are widely appreciated, orthodontic treatment remains an elective procedure. It, like any other treatment of the body, has some inherent risk and limitations. These are seldom serious, but should be considered in making the decision to undergo treatment. We urge you to read the following information and ask us any questions you may have. Please understand that we feel the benefits of orthodontic treatment far outweigh the risks.

PATIENT COOPERATION – THE MOST IMPORTANT FACTOR IN COMPLETING TREATMENT ON TIME.

The insufficient wearing of elastics, removable appliances, or headgear; broken appliances, missed appointments, and poor oral hygiene prevent the desirable results we anticipate. Lack of cooperation is the most common cause of excessive treatment time, increased fees, and disappointing results.

DECALCIFICATION AND CAVITIES

Good oral hygiene is a must during orthodontic treatment. Tooth discoloration & decay can occur if patients eat foods containing excessive sugar and/or if they do not brush their teeth properly. Inadequate cleaning can also cause gum disease and loose brackets/bands. Although gum problems can occur when not wearing braces, the risk is greater during orthodontic treatment.

PERIODONTAL PROBLEMS

Proper brushing and flossing can usually prevent swollen, inflamed and bleeding gums. Periodontal disease is most often caused by the accumulation of plaque and debris around the teeth and gums. However, unknown causes can also lead to progressive loss of supporting bone and gums. If periodontal problems become uncontrollable, orthodontic treatment may have to be discontinued prior to completion.

ROOT RESORPTION – SHORTENING OF ROOT ENDS

This can occur with or without orthodontic treatment. Under healthy conditions the shortened roots usually are no problem. Injury, impaction, endocrine or idiopathic disorders can also be responsible.

IMPACTED TEETH – TEETH UNABLE TO ERUPT NORMALLY

In attempting to move impacted teeth, especially cuspids, various problems are sometimes encountered which may lead to the loss of the tooth or periodontal problems. The length of time required to move such a tooth can vary considerably. Occasionally twelve year molars may be trapped under crowns of six year molars. Consequently the removal of third molars may prove necessary.

TEMPORO-MANDIBULAR JOINTS (TMJ) – THE SLIDING HINGE CONNECTING THE UPPER AND LOWER JAWS

Possible problems may exist or occur during or following orthodontic treatment. Tooth position and bite can be a factor in this condition. An equilibration by your dentist may be recommended after appliances are removed to improve occlusal relationship. TMJ problems are not all "bite" related. Remember that most individuals that have a TMJ problem have never had orthodontic treatment.

GROWTH PATTERNS – FACIAL GROWTH OCCURRING DURING OR AFTER TREATMENT

Uncorrected finger, thumb, tongue or similar pressure habits, unusual hereditary skeletal patterns, insufficient or undesirable growth can all influence our results, effect facial change and cause shifting of teeth during or following retention. Surgical procedures can frequently correct these problems. On rare occasions, it may be necessary to recommend a change in our original treatment plan.

RELAPSE – MOVEMENT OF TEETH FOLLOWING TREATMENT

Settling or shifting of teeth following treatment as well as after retention will most likely occur in varying degrees. Some of these changes may or may not be desirable. Rotations and crowding of lower anterior teeth are most common examples. Slight spaces in the extraction sites, or between some upper anterior teeth are other examples. Sometimes we might advise the wearing of a retaining appliance every night or a few evenings each week for an indefinite period.

PERIODONTAL PROBLEMS – GUM INFLAMMATION, BLEEDING, AND PERIODONTAL DISEASE

Swollen, inflamed and bleeding gums can usually be prevented by proper and regular flossing and brushing. Periodontal disease can be caused by accumulation of plaque and debris around the teeth and gums, but there are several unknown causes that can lead to progressive loss of supporting bone and recession of the gums. Should the condition become uncontrollable, orthodontic treatment may have to be discontinued short of completion. This would be rare, usually in adults with a pre-existing periodontal problem.

UNUSUAL OCCURRENCES

Swallowing an appliance, chipping a tooth, dislodging a restoration, an ankylosed tooth, and abscess or cyst may occur.

DENTAL CHECK-UPS

All necessary dentistry must be completed prior to our starting orthodontic therapy. It is essential that the patient maintain their regular examinations with their family dentist every six months during the treatment period. Adults must visit their dentist, hygienist or periodontist for scaling and cleaning every three to five months while being treated.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of them by the doctor in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form, and do realize the risks and limitations involved, and do consent to orthodontic treatment.

Patient/Parent/Guardian Signature:_____ **Date:**_____

Witness: _____ **Date:**_____

Hugh E. Friel D.D.S., M.D.S