Adult Health History

FOX ORTHODONTIC SPECIALISTS

Patient Information

Patient Name
New Shelby Yates Adult

Gender
M

Social Security #
888-88-8888

Date of Birth
01/01/2020

Driver's License #
fffffffffffffffffffff

House Address
86 North Cowley Boulevard, Nemo omnis ape

City
Iste quisquam suscip

State
AK

Zip Code
57813

Primary Phone Number
888-888-8888(Home)

Secondary Phone Number

Email Address
sachinc@qburst.com

Employer's Name
fffffffffffffffffffffffffffff

Occupation
fffffffffffffffffff

Spouse/Emergency Contact Information

Marital Status
Divorced

Spouse/Partner's Name
fWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWW

Emergency Contact Name
fWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW

Phone Number
888-888-8888

Relation to You
Child

House Address
86 North Cowley Boulevard

City
Iste quisquam suscip

State
AK

Zip Code
57813

Person Ok to release Protected Information to
fWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWW

Relation
Sibling

Insurance Information

Primary DENTAL Insurance Plan
other-fWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWW..

Phone Number
888-888-8888

Group #
fWWWWWWWWWWWWWWWWWW

Member ID
fWWWWWWWWWWWWWWWWWW

Issuer ID
fWWWWWWWWWWWWWWWWWW

Insurance Address
fWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW, fWWWWWWWWWWWW

Insurance City
fWWWWWWWWWWWWWWWWWWW

Insurance State
AZ

Insurance Zip Code
fWWWWWWWW

Coverage Type
Indemnity

Patient Relationship To Policy Holder
Self

Policy Holder's Name
NewShelby YatesAdult

Policy Holder's Social Security #
888-88-8888

Policy Holder's Birth Date
01/01/2020

Policy Holder's Employer
fffffffffffffffffffffffffff

Employer's Phone Number
888-888-8888

Co-pay (if known)
$99

Deductible (if known)
$999

Secondary DENTAL Insurance Plan

Phone Number

Group #

Member ID

Issuer ID

Insurance Address

Insurance City

Insurance State

Insurance Zip Code

Coverage Type

Patient Relationship To Policy Holder

Policy Holder's Name

Policy Holder's Social Security #

Policy Holder's Birth Date

Policy Holder's Employer

Employer's Phone Number

Co-pay (if known)
$

Deductible (if known)
$

Dental History

General Dentist	Last Visit	Referral Source	Name of person referring
fWWWWWWWWWWWWWWWWWWWWWWWWWWW	**01/2020**	**Family or Friend**	**fWWWWWWWWWWWWWWWWWWWWWWWWWWW**

Main Orthodontic Concerns
fWWWWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWWWWWfWWWWWWWWWWWWW

Have you visited an orthodontist before?
No

When?

Reason?

Have your adenoids or tonsils been removed?
Yes

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)?
Yes

Do you have any missing or extra permanent teeth?
Yes

Have you ever had an injury to (select all that apply)?
- [ ] Teeth
- [x] Mouth
- [ ] Chin

Do you have speech problems? If so, explain
Yes, fWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW

Gums bleed?
Yes

Chew or SmokeTobacco?
Yes

Do you like your smile?
No

Do you currently or have you ever had any of the following habits?
- [ ] Clenching/Grinding Teeth
- [ ] Nail biting
- [ ] Lip Sucking/Biting
- [x] Thumb/ Finger Sucking
- [ ] Mouth Breathing
- [ ] Chewing/Eating Problems

Medical History

Are you currently being treated by a physician? If yes, what reason(s)?
Yes, fWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWW WWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWWWf

Physician
fWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWW WWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWWf

Last Visit	Phone Number
01/2020	**888-888-8888**

Allergies or sensitivities? If yes, please list allergies
Yes, fWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWW WWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWW

Are you currently taking any prescription or over-the-counter medications? Please list, with dosage
Yes, fWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWW WWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWW

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of oflonimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)?
Yes

Have you had any serious illnesses or operations? If yes, describe
Yes, fWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWW WWWWWWWWWWWWWWWWWWfWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWfWWWWWWWW

Have you ever had a blood transfusion? If yes, give approximate dates
Yes, fWWWWWWWWWWWWWWWWWWWWWW

Check if you have or ever had any of the following

- [x] ADHD
- [ ] Anemia
- [ ] Arthritis, Rheumatism
- [ ] Artificial Heart Valves
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chemical Dependency
- [x] Chemotherapy
- [ ] Circulatory Problems
- [ ] Cortisone Treatments
- [ ] Cough, Persistent
- [x] Coughing Blood
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [ ] Headaches
- [ ] Heart Murmur
- [ ] Heart Problems
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mitral Valve Prolapse
- [ ] Pacemaker
- [ ] Radiation Treatment
- [ ] Respiratory Disease
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Shortness of Breath
- [ ] Skin Rash
- [ ] Stroke
- [ ] Swelling of Feet or Ankles
- [ ] Thyroid Problems
- [ ] Tobacco Habit
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Venereal Disease

Authorization

I declare that the information I have provided today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform the practice of any changes in my medical status. I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the practice. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

☑ I have read and agree to the Terms of Use and Privacy Policy

Responsible Party Name

New Shelby Yates Adult

Date

09/15/2020 04:32 PM

Responsible Party Signature

HIPAA Authorization

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of1996 (HIPAA). I understand that by signing this consent form, I authorize you and your business associates to use and disclose my protected health information to carry out

Treatment (including direct or indirect treatment by other health care providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day health care operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Practice Name

Qb Dental

Patient Legal Name

New Shelby Yates Adult

Responsible Party Name

New Shelby Yates Adult

Authorization

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Responsible Party Name

New Shelby Yates Adult

Date

09/15/2020 04:32 PM

Responsible Party Signature