



Dr. Randolph E. Schader

PATIENT INFORMATION - ADULT

Patient Name: _____ D.O.B. _____

Married ___ Single ___ Divorced ___ Widowed ___

Address: _____ City: _____ State: _____ Zip _____

Home #: _____ Cell #: _____

Email address: _____

Employer: _____

Occupation: _____ Work #: _____

I prefer to be contacted at/by _____

General Dentist: _____ Date last seen: _____

PRIMARY DENTAL INSURANCE

Policy Holder's Name: _____ DOB: _____

ID #/Social Security #: _____ Group #: _____

Employer: _____

Dental Insurance Plan Name & Address: _____

I am solely responsible for this account: yes ___ no ___

If no, please provide name, address and telephone number of responsible party:

REFERRAL INFORMATION

Name of person/office referring you to our practice: _____

Emergency contact (not living with you) : _____

Address: _____

Phone #: _____

Signature: _____

Date: _____



Dental and Health History

Name _____ D.O.B. _____ Gender M F
 First Middle Last

Dental Orthodontic History	Yes	No	Additional Information
Thumb/Finger sucking			
Tongue thrust			
Clenching/Grinding teeth			
Mouth breathing habit, snoring or difficulty in breathing			
Chipped or otherwise injured primary (baby) or permanent teeth			
Difficulty in chewing or jaw opening			
Had periodontal (gum) treatment			
Teeth sensitive to hot or cold			
Speech problems			
Supernumerary (extra) or congenitally missing teeth			
Had prior orthodontic examination or treatment			
Bleeding gums, bad taste or mouth odor			
Periodontal "gum" problems			
Any pain or soreness in the muscles of the face or around the ears			
Aware of any loose, broken or missing restorations (fillings)			
Using any forms of fluoride			
Suffered injuries to your face, mouth, teeth or chin			

Medical History	Yes	No
Abnormal Bleeding		
Hypertension		
ADD or ADHD		
AIDS/HIV		
Any operation		
Artificial Joints/Valves		
Asthma		
Autism		
Cancer		
Congenital Heart Disorder		
Convulsions		
Diabetes		
Epilepsy		
Handicaps/Disabilities		
Heart Murmur		
Hemophilia		
Hepatitis		
Kidney Problems		
Liver Problems		
Mitral Valve Prolapse		
Prosthetics		
Rheumatic Fever		
Scarlet Fever		
Sickle Cell Disease		
Tuberculosis (TB)		

Medical History

Primary Physician _____

Phone Number _____

Last Visit _____

Current Physical Health is: Good ___ Fair ___

Poor ___ Explain _____

List medications currently taking

Is pre-med required for dental visits (please circle) No Yes

Explain _____

Allergies to medications: No ___ Yes ___ Explain _____

Other allergies No ___ Yes ___

Latex ___ Metals ___ Nickel ___ Plastic ___ other _____

Authorization

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is my responsibility to inform Newtown Orthodontics of changes in my child's or my own medical status. I authorize the orthodontic staff to perform the necessary dental and/or orthodontic services on my child (if applicable) or myself as needed.

 Patient signature (legal guardian if minor)

 Date

**HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

**Randolph Schader, DDS, MS
Newtown Orthodontics LLC
46 Blacksmith Rd, "Suite Tooth"
Newtown, PA 18940**

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

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. 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 / FACILITY'S IN THE FUTURE.

Please **print** patient name

Parent/Guardian Please **sign**

Legal Representative

Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

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: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

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