Dr. Dann IV
Orthodontics
For Children and Adults

Catch the Perfect Bite!

ORTHODONTIC PATIENT QUESTIONNAIRE

Today's Date: _____ E-Mail Address: _____

Patient Name: _____
LAST FIRST MI

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: _____ SS # _____

School: _____ Grade: _____

Hobbies and interests: _____

Home Address: _____
STREET APT./CONDO #

_____
CITY STATE ZIP CODE

Home #: (____) _____ Cell/Other #: (____) _____

Patient Work #: (____) _____ Ext # _____ Employer: _____

General Dentist: _____ Last Cleaning: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Name of Responsible Party for account: _____

Social Security #: _____ Relationship to Patient: _____

Work: (____) _____ Ext # _____ Employer: _____

Spouse: _____ Birthdate: ____/____/____ SS# : _____

Employer: _____ Work #: (____) _____ Ext # _____

- - - - - - - - - - - - - - - - **IF PATIENT IS A MINOR, PLEASE COMPLETE BELOW** - - - - - - - - - - - - - - - -

Father's Name: _____ Birthdate: ____/____/____

Home #: (____) _____ Work #: (____) _____ Ext # _____

Address: _____ Marital Status: _____

Employer: _____ SS #: _____

Mother's Name: _____ Birthdate: ____/____/____

Home #: (____) _____ Work #: (____) _____ Ext # _____

Address: _____ Marital Status: _____

Employer: _____ SS #: _____

ORTHODONTIC INSURANCE INFORMATION:

Orthodontic Coverage: ☐ Yes ☐ No Insurance Co.: _____

Policy Holders Name: _____ SS # _____

Group # _____ Policy # _____

Ins. Co. Phone # (____) _____ Secondary Ins.: _____

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Previous orthodontic evaluation or treatment: ☐ Yes ☐ No

Previous oral surgery: ☐ Yes ☐ No

If yes, describe: _____

Y N Pain or discomfort in the jaw joint (TMD)

Y N History of clenching or grinding teeth

Y N History of muscle soreness

Y N History of ringing in ears

Y N History of headaches

Y N History of backaches

Y N History of chronic pain

Y N Have there been injuries to the face, mouth or teeth

If yes, describe: _____

Y N Mouth breather

Y N Thumb/finger sucking

Y N Tongue thrust

Y N Speech problems

Y N Difficulty sleeping

Y N Missing or extra permanent teeth

Y N Significant medical history

If yes, describe: _____

Y N Arthritis (Rheumatoid, Osteo-Arthritis)

Y N History of heart problems/Rheumatic fever

Y N Allergies: _____

Y N Drug Allergies: _____

Y N Tested for HIV/AIDS: Date ____/____/____ Results: _____

Y N Tested for Hepatitis: Date ____/____/____ Results: _____

Y N Tested for Tuberculosis: Date ____/____/____ Results: _____

List any past serious illness: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

_____ _____

Signature Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

DR. CARL DANN, DDS, MS.

SPECIALIST IN ORTHODONTICS

Section A: Patient Information

Name: _____

Address: _____

_____

Home phone: _____Work phone: _____

Section B: To the patient-please read the following statements carefully

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out necessary treatment, payment activities, and healthcare operations which includes other healthcare professionals directly related to your treatment and insurance companies.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notices, at any time by contacting:

HIPPA Coordinator for Dr. Dann
2200 E. Robinson St., Orlando, FL., 32803
Phone: 407-894-3271
Fax: 407-895-5677 or 407-671-1394
Email:HIPPA@orthodrdann.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Who else is allowed to access information regarding your treatment or account status?

- Spouse: _____
- Sibling:_____
- Parents:_____
- Grandparents:_____
- None:_____
- Other: _____

Signature

I, _____, have had full opportunity to read and consider the content of this Consent form and your Notice Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of necessary protected health information to carry out treatment, payment activities, and health care operations.

Signature:_____ Date: _____

If this Consent is signed by personal representative on behalf of the patient, complete the following:

Parent or Legal Guardian:_____

Relationship to Patient:_____

Dr. Dann IV
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(Print) Name:_____

(Signature):_____

Date:_____

Please list your current medications:

_____

_____

_____

_____

_____

Are you taking bisphosphonate medication? Y / N

(Examples):

Intravenous ibandronate (Zometa/Aredia) Y / N

(often used in treatment of lung disease, breast disease, prostate cancer)

Oral tabs alendronate, risedronate, ibandronate Y / N

(Fosamax, Actonel, Boniva, Didronel/often used for osteoporosis & osteopenia)

These medications may interfere with bone production which is essential for successful orthodontic treatment. Some risks include inhibition of tooth movement,decreased bone healing, and possible osteonecrosis**.** Intravenous bisphosphonate has high risk. Oral bisphosphonate has low risk.

Are you aware of any other health issues that you may have that could adversely affect orthodontic treatment? Y / N

If yes, please explain:_____

_____

_____

_____

_____

2200 EAST ROBINSON STREET • ORLANDO, FL 32803
PH 407.894.3271 / FX 407.895.5677

www.OrthoDrDann.com

7221 ALOMA AVE, STE 100 • WINTER PARK, FL 32792
PH 407.671.4262 / FX 407.671.1394

DR. CARL DANN IV, DDS, MS
PRIVACY NOTICE

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 order to obtain payment of your account (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 member 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 much be filed within 180 days of violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protect 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;
- 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 not that we are not obligated to:
- Honor any request by you restrict the use or disclosure of your treated health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide and 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 the Notice, please ask for our Privacy Contact Person or direct your question 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, Parent, or Legal Guardian **Date**