

## Adult Dental/Medical Health History Form

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 (first) (middle) (last)

### DENTAL

**YES NO**

- Are you presently in any dental pain?
- Have you ever experienced any unfavorable reaction to dentistry?
- Have you ever knocked out or chipped any teeth?
- Have you been informed of extra or missing teeth?
- Is any part of your mouth sensitive to temperature or pressure?
- Do you brush your teeth daily?
- Do you floss regularly?
- Do your gums bleed when you brush?
- Do you predominantly breathe through your mouth?
- Do you require any pre-medication for dental procedures?
- Do you smoke or use tobacco products in any form?
- Have you ever had any pain / tenderness in your jaw (TMJ / TMD)?
- Are you aware of any jaw clicking or popping?
- Do you clench or grind your teeth?
- Have you ever experienced chronic ringing in your ears?
- Do you have "tension" headaches?
- Do you have any difficulty chewing or swallowing food?
- Are you aware that some appointments will be during work hours?

What is your primary concern with your teeth? \_\_\_\_\_

Have you previously consulted an orthodontist? \_\_\_\_\_

Are you aware of any dental work that needs to be completed prior to orthodontic treatment? \_\_\_\_\_

Date of your most recent dental examination: \_\_\_\_\_

Have there been any injuries to your face, mouth, teeth or chin? If yes, please explain: \_\_\_\_\_

Have any teeth been removed by extraction? If yes, please explain: \_\_\_\_\_

Has anyone else in your family received orthodontic treatment? If yes, how did they feel about the results? \_\_\_\_\_

### MEDICAL

**YES NO**

**Have you ever had any of the following diseases or medical conditions?**

- Abnormal Bleeding / Hemophilia
- Anemia
- Arthritis
- Asthma or Hayfever
- Blood Disorders
- Congenital Heart Defect
- Diabetes
- Dizziness
- Epilepsy
- Gastrointestinal Disorders
- Heart Problems
- Heart Murmur
- Hepatitis / Liver Problems
- Herpes
- High Blood Pressure
- HIV+ / AIDS
- Kidney Problems
- Nervous Disorders
- Pneumonia
- Prolonged Bleeding
- Radiation / Chemotherapy
- Rheumatic Fever
- Tuberculosis
- Tumor or Cancer

Do you have any other medical conditions not described above?  
 If yes, please explain: \_\_\_\_\_

### FEMALE PATIENTS:

**YES NO**

- Are you pregnant? Week # \_\_\_\_\_
- Are you taking birth control pills?
- Are you anticipating becoming pregnant?

(continued...)

(continued...)

**YES NO Do you have allergic reactions to any of the following?**

- Penicillin
- Erythromycin
- Dental Anesthetics
- Aspirin
- Tetracycline
- Codeine
- Metal / Jewelry

Please list any other medications to which you have had an allergic reaction: \_\_\_\_\_  
\_\_\_\_\_

Please list all medications that you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of a physician? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Please explain any medical problems that you have had in the past: \_\_\_\_\_  
\_\_\_\_\_

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical / dental status.

We will discuss your treatment with parents / legal guardians / the person financially responsible for your treatment / referring Doctor / Dentist for the the furtherment of your treatment.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

## Medical History Updates or Changes

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Comments: \_\_\_\_\_

Comments: \_\_\_\_\_

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Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Thank you for filling out this form completely. It will enable us to help you more effectively. Please do not hesitate to ask any questions; we are always happy to help.

**PATIENT INFORMATION**  
**(PLEASE COMPLETE ALL FIELDS THAT APPLY)**

Today's date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
(First) (Middle) (Last)

Email \_\_\_\_\_ Birth date \_\_\_\_\_

SS # \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_ how long at this address? \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Mobile # \_\_\_\_\_

Wk Phone \_\_\_\_\_ May we contact you at work? Y N

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Years employed? \_\_\_\_\_

**Patients spouse information**

Spouse Name \_\_\_\_\_

Birth date \_\_\_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Years employed? \_\_\_\_\_

**Mother's information**

Name \_\_\_\_\_  
(First) (Middle) (Last)

Email \_\_\_\_\_ Birth date \_\_\_\_\_

SS # \_\_\_\_\_ Marital Status M S W D

Home Address \_\_\_\_\_ How long at this address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Mobile # \_\_\_\_\_

Wk Phone \_\_\_\_\_ may we contact you at work? Y N

Employer \_\_\_\_\_ Years employed? \_\_\_\_\_

Occupation \_\_\_\_\_ Stepfather name \_\_\_\_\_

**(OVER)**

**Father's Information**

Name \_\_\_\_\_  
(First) (Middle) (Last)

Email \_\_\_\_\_ Birth date \_\_\_\_\_

SS # \_\_\_\_\_ Marital Status M S W D

Home Address \_\_\_\_\_ How long at this address? \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Mobile # \_\_\_\_\_

Wk Phone \_\_\_\_\_ may we contact you at work? Y N

Employer \_\_\_\_\_ Years employed? \_\_\_\_\_

Occupation \_\_\_\_\_ Stepmother name \_\_\_\_\_

**Insurance**

Primary Insurance \_\_\_\_\_ Cardholder \_\_\_\_\_ SS# \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Cardholder \_\_\_\_\_ SS# \_\_\_\_\_

Other Insurance \_\_\_\_\_ Cardholder \_\_\_\_\_ SS# \_\_\_\_\_

**Emergency contact information**

\_\_\_\_\_  
(Name) (Phone #) (Relationship)

\_\_\_\_\_  
(Name) (Phone #) (Relationship)

General Dentist \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

I undersigned accept financial responsibility for the above patient. A finance charge of \$15.00 dollars will be assessed on accounts over 30 days past due. I/we authorize the release of any dental information required to process insurance claims. I/our signatures may be used for that purpose. Copy of this authorization is as valid as the original.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
(18 years or older)

Mother \_\_\_\_\_ Date \_\_\_\_\_

Father \_\_\_\_\_ Date \_\_\_\_\_

# **PRIVACY CONSENT**

**This form is optional under the new patient privacy regulations recently issued by the United States Department of Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.**

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email address, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Thank You for your cooperation. Please let us know if you have any question.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature (If 18yrs or older)

\_\_\_\_\_  
Parent, or legal Guardian signature

Copus Orthodontics  
Dr. David Copus DDS MS PC  
4131 Shrestha Dr.  
Bay City, MI 48708  
989-667-5980

**IDENTITY THEFT DETECTION AND RESPONSE  
POLICY AND PROCEDURES FOR COPUS  
ORTHODONTICS**

**I. Policy**

This office has adopted an Identity Theft Detection and Response Policy and Procedures Program ("Program") pursuant to the Federal Trade Commission's Red Flag Rules ("Rules"). The purpose of the Program is to assist in detecting, preventing, and mitigating instances of possible identity theft in connection with patients in our practice. It does so by (a) requiring us to verify the identity of all new patients, (b) establishing certain "Red Flags" that could indicate possible identity theft, and (c) requiring follow up on any incident which triggers a Red Flag. The Program must be observed by all employees of this practice, including the professional, administrative, and clerical staff,

**II. Red Flags that May Indicate Identity Theft:**

1. An individual falsely claiming to be someone else who is known to the office staff;
2. Unexplained discrepancies between the patient's medical records and the patient's physical condition.
3. A discrepancy between the address contained in the patient's consumer credit report and the address provided by the patient; [include this in your program only if the practice obtains credit reports in connection with providing patient services]
4. A report by a patient known to the office staff that he or she has been the victim of identity theft in connection with oral health care services provided by the practice;

**III. Responding to Red Flags**

Any employee of this practice who encounters a Red Flag situation or any other activity that may indicate identity theft should report the situation to Dr. David Copus and staff. That person/s will follow up as appropriate and will record the incident and its handling in a Red Flags Log kept in this office.

**Possible responses to a Red Flag Situation include the following:**

**a. Patient notification**

The practice may notify the patient if a Red Flag is encountered that involves that patient's identity. Notification may be provided by mail, by telephone, or in-person – as the practice deems appropriate. The notification may include verification that the patient has not been victimized by identity theft in connection with any visits to the practice.

In some instances, additional specific action will be required:

- If notice of an actual identity theft is received, we will immediately cease any collection efforts that are related to the identity theft.

If a consumer credit report contains an address different from the address provided by the patient, the correct address will be verified with the patient. If

- the verified address is different from the address in the credit report, we may report the verified address to the credit reporting agency.

**b. Notification of Legal Authorities**

If the practice obtains specific information pertaining to a person committing identity theft, we will provide that information to law enforcement to the extent permitted under HIPAA and other privacy rules. We may seek advice of legal counsel on the issues involved.

Of course, if a Red Flag is triggered but we determine that there clearly has been no identity theft, no action will be taken.

**IV. Plan Administration and Updates**

All employees of this practice will receive a copy of this Policy and will be instructed as to its procedures. We will ask each employee to sign an acknowledgement of receipt and understanding. We will evaluate our Program annually and update it in light of experience. Any questions about this Policy should be addressed to Dr.David Copus and Staff.

**IMPORTANT NOTE:** While this model Policy attempts to provide dentists with the tools needed to comply with the Red Flag Rules, it has not been approved by the Federal Trade Commission ("FTC"). It should not be treated or considered as legal advice or as applicable to each dental practice. Rather, each practice should adapt this model Policy in light of its own experience and the advice that it receives from its counsel. We will provide updates as new information becomes available.

**ACKNOWLEDGEMENT**

I, \_\_\_\_\_, have read the practice's Identity Theft Detection and Response Policy and Procedures and understand the contents. I have been instructed regarding situations that may suggest possible identity theft as described in the Identity Theft Detection and Response Policy and Procedures. If I discover a possible instance of identity theft, I will immediately bring the matter to the attention of Dr.David Copus and staff.

Signature of responsible party:

\_\_\_\_\_

Date \_\_\_\_\_