Welcome to Copus Orthodontics

We would like to welcome you to our office. In an effort to provide the best service possible. We ask that you fill out this form as completely as possible. Thank you for your cooperation.

1. Patient Information-Adult

Marital Status: (circle) Single Married Widowed Divorced Separated Domestic Partner

Patient's Name_____Age_____Birth Date_____
(First) (Middle) (Last)

Nickname (if preferred)_____ _____ Male or Female SS#_____

Home Phone_____ Cell Phone_____ Email_____

Home Address_____City, State, Zip_____

Employer_____ Occupation_____How Long? _____

Work Phone_____ May we contact you at work? YES or NO

Patient's General Dentist_____How did you hear about our office? _____

Have we treated another member of your family? YES or NO If YES, Name_____

Spouse Name_____ Spouse's Phone_____

Spouse's employer _____ How Long?_____

2. DENTAL INSURANCE

Does this policy cover Orthodontics? YES NO I don't know

If you have answered NO to the above question, you do NOT need to complete the remaining Insurance questions.

PRIMARY POLICY INFORMATION:

INSURANCE CO. NAME_____
Policy Holder's Name:_____Birth Date_____
Relationship to the patient_____ Policy Holder's SS#_____
Policy Holder's Employer_____

SECONDARY POLICY INFORMATION:

INSURANCE CO. NAME_____
Policy Holder's Name:_____Birth Date_____
Relationship to the patient_____ Policy Holder's SS#_____
Policy Holder's Employer_____

3. FINANCIALS

Who is financially responsible for this account? SELF or OTHER

If other please supply the following information:

Name_____ Relationship to patient_____

Address_____City, State, Zip _____

Home Phone_____ Cell Phone_____

Employer_____Occupation_____How Long?_____

Work Phone_____ May we contact this person at work? YES or NO

SS#_____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any personal, medical or insurance changes.

Signature_____Date_____
(Required)

I HEREBY AUTHORIZE ORTHOBANC, LLC, ON BEHALF OF DAVID T. COPUS DDS MS PC TO OBTAIN A COPY OF MY CREDIT REPORT FROM A CREDIT REPORTING AGENCY FOR THE PURPOSE OF CONSIDERING PAYMENT OPTIONS.

Signature_____date_____
(Optional)

Please list any additional people whom we may share the patient's treatment, scheduling and financial information with.
Due to the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") any person not specifically named on this form will NOT be able to obtain any information.

Name:	Relationship to the patient:
_____	_____
_____	_____

CopusOrthodontics

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Adult Dental/Medical Health History Form

Patient's Name: _____ Date: _____
(first) (middle) (last)

DENTAL

YES	NO	
☐	☐	Are you presently in any dental plan?
☐	☐	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: _____

_____

YES	NO	**Do you have allergic reactions to any of the following?**
☐	☐	Penicillin
☐	☐	Erythromycin
☐	☐	Dental Anesthetics
☐	☐	Aspirin
☐	☐	Tetracycline
☐	☐	Codeine
☐	☐	Latex
☐	☐	Metal

(continued...)

(continued...)

FEMALE PATIENTS:

YES	NO	
☐	☐	Are you pregnant? Week # _____
☐	☐	Are you taking birth control pills?
☐	☐	Are you anticipating becoming pregnant?

ALL PATIENTS:

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: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Signature: _____	Signature: _____	Signature: _____

Thank you for filling out this form completely. It will enable us to help you more effectively.
If you have any questions, please do not hesitate to ask us. We are always happy to help.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name_____

Signature_____

Relationship to Patient_____

Date_____