LOWE ORTHODONTICS
Spectacular Smiles, Exceptional Experience

Zachton J Lowe DDS MSD

Tell Us About Yourself

Today's Date: ____/____/____ Name:_____ Male__ Female__ Age:_____
LAST FIRST MI

I Prefer to be Called:_____ Date of Birth: ____/____/_____

Single__ Married__ Divorced__ Separated__ Widowed__ Partner__

Cell Phone #: (____)_____ Home Phone #:(____)_____ Work Phone #: (____)_____ Ext._____

Your Home Address: _____
STREET CITY STATE ZIP

Primary E-Mail Address:_____

Employer: _____Job Title: _____

General Dentist:_____ I was referred by:_____

Family Members in treatment in our office:_____

Hobbies/Sports:_____

Spouse Information

Name:_____ Date of Birth: ___/___/_____ Cell Phone #: (_____)_____

Employer: _____ E-mail Address:_____

Dental Insurance Information

PRIMARY INSURANCE Orthodontic Coverage? __YES __NO (If no leave the rest blank)

Insurance Co:_____ Group # (Plan, Local, or Policy #): _____ ID #:_____

Subscriber's Name: _____ Relation to patient: _____

Subscriber's Birth Date: ___/___/_____ Social Security #:_____-____-_____ Subscriber's Employer:_____

SECONDARY INSURANCE Orthodontic Coverage? __YES __NO (If no leave the rest blank)

Insurance Co:_____ Group # (Plan, Local, or Policy #): _____ ID #:_____

Subscriber's Name: _____ Relation to patient: _____

Subscriber's Birth Date: ___/___/_____ Social Security #:_____-____-_____ Subscriber's Employer:_____

General / Dental Information

What major concerns do you have that you would like the doctor to address? _____

_____

Describe any previous orthodontic treatment or consultations._____

Do you have any current dental problems or problems with past treatment?_____

Do you have any pending dental work?_____

Do you take any antibiotic pre-medication before any dental procedures?_____

Have there been any injuries to the: __Face __Mouth __Teeth __Chin __None

Have Adenoids been removed? __YES __NO Tonsils? __YES __NO Date of Surgery(s)? ___/___/_____

Have you been informed of any missing or extra permanent teeth? __YES __NO

Have you ever had any treatment / pain / tenderness in your jaw joint (TMJ/TMD)? __YES __NO

Do you like your smile? __YES __NO Have you been diagnosed or treated for gum disease? __YES __NO

Is your current dental health: __GOOD __FAIR __POOR

Do you have any speech problems? __YES __NO Do you clench your teeth? __YES __NO Grind? __YES __NO

Do you breathe through your mouth? __YES __NO Awake or Asleep? (Please circle which applies)

Do you smoke? __YES __NO How much?_____

Medical History

Your Physician: _____ Phone #: (____)_____ Date of last visit: ___/___/_____

Please describe your current physical health: __Good __Fair __Poor

Please list all medications and supplements that you are taking (Prescription and over the counter) :_____

_____

Have you in the past or are you currently taking Bisphosphonates? __YES __NO _____

Please list any Allergies you have (Drugs, Environmental, Etc.):_____

For Women: Are you pregnant? __YES __NO Week#:____

Have you experienced any of the following problems/issues? (PLEASE CIRCLE THOSE THAT APPLY)

Abnormal Bleeding/Bruising/Anemia	Arthritis or Joint Problems	Asthma or Sinus Problems
Birth/Hereditary Problems	Bone Fractures/Major Injuries	Cancer/Chemotherapy/Radiation
Cold Sores OR Herpes	Diabetes or Hypoglycemia	Difficulty Breathing/ Emphysema
Disabilities	Drug/Alcohol Abuse	Eating Disorders
Endocrine or Thyroid Problems	Epilepsy/Seizures/Fainting	Heart Attack/Stroke/Angina
Heart Defect/Murmur	Heart Surgery/Pacemaker	Hepatitis/Liver Problems
High/Low Blood Pressure	HIV/AIDS	Hospitalized for any reason
Immune System	Kidney Problems	Mental Health/Depression
Osteoporosis	Polio/TB/Mono/Pneumonia	Rheumatic Heart Disease
Severe/Frequent Headaches	Skin Disorder	Sleep Apnea
STDs	Ulcers/Hyperacidity/Reflux	Vision and Hearing Problems

Please give details of medical problems circled above or others:_____

_____

_____

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Patient Signature_____ Date_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Patient Signature_____ Date_____

Privacy Consent

Authorization For Release of Patient Information I acknowledge that I have been offered a copy of the Lowe Orthodontics Notice of Privacy Practices. I hereby authorize the above doctor(s) to provide other health care providers with information regarding this orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below:

- ☐ No one
- ☐ Any immediate family member
- ☐ Spouse only
- ☐ Other (Please Specify):_____

Patient Name_____

Patient Signature_____ Date_____

Authorization and Consent To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Lowe Orthodontics to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Lowe Orthodontics health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Lowe Orthodontics may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Lowe Orthodontics does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Lowe Orthodontics already sent before receiving my written instructions to stop.

Patient Signature_____ Date_____