



Beautiful Smile...
Lasting Impression

Adult Registration Form

This form should be used for all patients 18 years of age and over. The form should be completed and signed by the patient.

Patient Information

Date

Patient's name

Last First Middle

Residence

Street City Zip

Home phone Cell Work

E-mail Birth date

Occupation Social Security #

Employer No. years employed

How did you hear about our office?

Spouse Name

Last First Middle

Residence

Street City Zip

Home phone Cell Work

E-mail Birth date

Employer Social Security #

Occupation No. years employed

Additional Responsible Party Information

Name

Last First Middle

Relationship to patient

Residence

Street City Zip

Home phone Cell Work

E-mail Birth date

Occupation Social Security #

Employer No. years employed

Please continue on next page ->

## Dental Insurance Information

Insured's Name \_\_\_\_\_ Contract/ SS # \_\_\_\_\_

Company and address \_\_\_\_\_

Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

### Additional Dental Insurance:

Insured's Name \_\_\_\_\_ Contract/ SS # \_\_\_\_\_

Company and address \_\_\_\_\_

Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Emergency Contact Information

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Street City Zip

E-mail \_\_\_\_\_

## Dental History

Dentist \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

**I authorize Kennet Orthodontics to share clinical information with other dental professionals to ensure optimal dental health and best possible results.** \_\_\_\_\_

Signature

What concerns you most about your teeth? \_\_\_\_\_

Please circle Yes or NO (If Yes, please fill in details)

Yes No Are you presently in any dental pain? \_\_\_\_\_

Yes No Have there been any injuries to face, mouth or teeth? \_\_\_\_\_

Yes No Do you have any type of thumb or tongue habits? \_\_\_\_\_

Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_

Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_

Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_

Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_

Yes No Do you have tension headaches? \_\_\_\_\_

Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_

## Medical History

Physician \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Please continue on next page →**

Please circle Yes or NO (If Yes, please fill in details)

Are you taking any medication?	Yes	No	_____
Are you allergic to any medication?	Yes	No	_____
Is there a history of a major illness?	Yes	No	_____
Is there a history of major operations?	Yes	No	_____
Is there a history of a serious accident?	Yes	No	_____
Are you pregnant?	Yes	No	_____

Circle yes or no if you have had or currently have any of the following medical conditions.

Nervous Disorders	Y / N	Arthritis	Y / N	Heart Problems	Y / N
Asthma / Hay fever	Y / N	Heart Murmur	Y / N	Prolonged Bleeding	Y / N
Bone Disorders	Y / N	Hepatitis/Liver Problems	Y / N	Radiation/Chemotherapy	Y / N
Herpes	Y / N	Rheumatic Fever	Y / N	Diabetes	Y / N
Tuberculosis	Y / N	Dizziness	Y / N	HIV/ Aids	Y / N
Tumor or cancer	Y / N	Epilepsy	Y / N	Kidney Problems	Y / N
Pneumonia	Y / N	High Blood Pressure	Y / N	Heart Defect	Y / N
Abnormal bleeding/Hemophilia	Y / N	Gastrointestinal Disorders	Y / N		
Are there any medical conditions not mentioned above?	Y / N				

If you answered yes to any question, please give details here \_\_\_\_\_

\_\_\_\_\_

**I have truthfully answered all the questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Kennet to perform a complete orthodontic evaluation.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## HIPAA

Effective April 14, 2003 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

### Patient Acknowledgment/Consent

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

**Signature:** I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_