Kennet Orthodontics
www.kennetortho.com

Beautiful Smile…
Lasting Impression

Adult Registration Form

This form is for patients 18 years of age or over and should be completed and signed by the patient.

Patient Information

Date___________________

Patient's name____
Last First Middle

Address____
Street City Zip

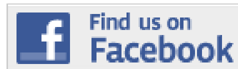
Home phone________________________ Cell ________________________ Work phone __________________

E-mail____ Birthdate ______/______/______

Occupation____ Social Security #___________________

Employer____ No. years employed___________

How did you hear about our office? ____

Are you on **Facebook**? Yes No We are! 

www.facebook.com/kennet.orthodontics

Spouse Information

Name____
Last First Middle

Address ____
Street City Zip

Home phone _________________________Cell ___________________________Work ___________________

E-mail____ Birth date ______/______/__________

Occupation____ Social Security #___________________

Employer____ No. years employed___________

Additional Responsible Party Information

Name ____
Last First Middle

Relationship to patient____

Address____
Street City Zip

Home phone ________________________Cell __________________________Work ______________________

E-mail____ Birth date ______/______/__________

Occupation ____ Social Security #______________________

Employer ____ No. years employed____________

Emergency Contact Information

Name of nearest relative not living with you____

Address____
Street City Zip

Home phone ________________________Cell __________________________Work ______________________

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19991 Hall Road, Suite 101 ▪ Macomb, Michigan 48044 ▪ Phone: 586-416-4455 ▪ Fax: 586-416-4422

Dental Insurance - Primary

Policyholder's Name____ Birthdate: ______/______/_________

Insurance company name: ____

Insurance company address____

Insurance Phone # ______________________________Group # _________________ Contract/ SS #______________________

Dental Insurance - Secondary:

Policyholder's Name____ Birthdate: ______/______/_________

Insurance company name: ____

Insurance company address____

Insurance Phone # ______________________________Group # ________________ Contract/ SS #______________________

Dental History

Dentist Name ____ Date of last visit________/_________/__________

Address/City: ____ Phone # ________________________

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)

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 thumb-sucking 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?	Yes	No	____________________________
Do you have a fear of the dentist?	Yes	No	____________________________

Medical History

Physician Name ____ Date of last visit_____/______/________

Address____ Phone___________________________

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

Are you allergic to Latex? Yes No ____

Are you taking any medication?	Yes	No	____________________________
Medication taken for:			____________________________
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	____________________________
If you answered yes to any question, please give details here			____________________________

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Please continue on next page ➔

Circle Yes or No if you have had or currently have any of the following medical conditions:

Nervous Disorders	Yes	No	Arthritis	Yes	No	Heart Problems	Yes	No
Asthma / Hay fever	Yes	No	Heart Murmur	Yes	No	Prolonged Bleeding	Yes	No
Bone Disorders	Yes	No	Hepatitis/Liver Problems	Yes	No	Radiation/Chemotherapy	Yes	No
Herpes	Yes	No	Rheumatic Fever	Yes	No	Diabetes	Yes	No
Tuberculosis	Yes	No	Dizziness	Yes	No	HIV/ Aids	Yes	No
Tumor or cancer	Yes	No	Epilepsy	Yes	No	Kidney Problems	Yes	No
Pneumonia	Yes	No	High Blood Pressure	Yes	No	Heart Defect	Yes	No
Gastrointestinal Disorders	Yes	No				Abnormal bleeding/Hemophilia	Yes	No

If you answered yes to any question, please give details here: ____

____

Are there any medical or mental conditions not mentioned above? Yes No

Please explain: ____

Do you have learning disabilities or need assistance with instructions? Yes No

Please explain: ____

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

Patient's 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. Any electronic communication may not be secure.

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:** ________________