ZACHARY P. EHRMANTROUT DDS•PS

Creating Spectacular Smiles

Patient Information

Date_____

Last Name	First	Nickname	Birth Date	Age	M	F
Address	City	Zip	Phone			

Has any member of your family undergone orthodontic treatment? Yes____ No____ Name_____

Patients Dentist: | Whom may we thank for referring you?

Responsible Party Information

Name_____ (Last / First / Middle) _____ Marital Status

Residence_____ (Street / City / State / Zip)

Mailing Address_____ (Street / City / State / Zip)

How long at this address?_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.)_____ (Street / City / State / Zip)

Email Address_____

Social Security #_____ Birth Date_____ Relationship to patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ (Last / First / Middle) Relationship to patient_____

Social security #_____ Birthdate_____ Relationship to patient_____

Employer_____ Occupation_____ No. Years Employed_____

Orthodontic Insurance Information

Insured Person's Full name_____ Date of Birth_____

Social Security #_____ Relationship to Patient_____ Work Phone_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone_____

Employer Name_____ Employer Address _____

Do you have other orthodontic coverage? YES___ NO___

Insured Person's Full Name_____ Date of Birth_____

Social Security #_____ Relationship to Patient _____ Work Phone_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone_____

Employer Name_____ Employer Address_____

Name of nearest relative not living with you _____ Phone_____

Signature (Parents signature if minor)_____

Health Questionnaire

Name of Physician_____ City_____

PLEASE "X" NEXT TO EACH IFTHE ANSWER IS "YES", LEAVE BLANK IF "NO"
HAVE YOU HAD.....

__HEART PROBLEMS
__HIGH BLOOD PRESSURE
__ LOW BLOOD PRESSURE
__ CIRCULATORY PROBLEMS
__ RHEUMATIC FEVER
__ HEPATITIS
__ DIABETES
__ RADIATION TREATMENTS

__EPILEPSY
__ KIDNEY PROBLEMS
__ NERVOUS PROBLEMS
__ TUBERCULOSIS
__ EXCESSIVE BLEEDING
__ CEREBRAL PALSY
__ SCARLET FEVER
__ MALIGNANCIES

__CHRONIC SINUS
__ CHRONIC EAR PROBLEMS
__ ANEMIA
__ ARTHRITIS
__ ADENOIDS REMOVED
__ A.I.D.S.
__ H.T.L.V.
__ VENEREAL DISEASE/HERPES

OTHER HEALTH COMPLICATIONS NOT LISTED ABOVE_____

ARE YOU ALLERGIC TO:

____PENICILLIN _____ LATEX ____ CODEINE ____ LOCAL ANESTHETICS _____

OTHER
Allergies:_____

ARE YOU PREGNANT? _____ IF YES, HOW MANY MONTHS?_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:_____

_____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU FEEL THE DOCTOR SHOULD BE AWARE OF:_____

_____

HAVE YOU BEEN HOSPITALIZED IN THE LAST TWO YEARS? ____YES ____NO

IF YES, PLEASE EXPLAIN:_____

_____

DENTAL HEALTH INFORMATION

NAME OF DENTIST _____ CITY _____ DATE OF LAST VISIT _____

HAVE YOY HAD ANY INJURY TO THE MOUTH/JAW AREA?_____
IF YES, PLEASE EXPLAIN_____

WHEN AND WHERE WERE YOUR LAST DENTAL X-RAYS
TAKEN?_____

IS THIS YOUR FIRST ORTHODONTIC VISIT?_____

FOR ALL PATIENTS

HAS THE DENTIST POINTED TO SOME ORTHODONTIC PROBLEM? _____ WHAT?_____

ANY PAIN OR CLICKING ON OPENING MOUTH?_____

PLEASE LIST ANY EXPERIENCES OR PROBLEMS YOU WOULD LIKE THE DOCTOR TO BE AWARE OF:_____

IF THE PATIENT IS A CHILD

_____THUMB SUCKING ____TONGUE THRUSTING ____MOUTH BREATHING

Creating Spectacular Smiles

Hawks Prairie : (360) 491-4884 West Olympia : (360) 352-6376

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify)

_____
_____
_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about or privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice take effect 01/01/2009, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: in addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family, Friends and Persons Involved in Care: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up fell prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Court Orders and Subpoenas: We may disclose information in response to an appropriate court order or subpoena.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.