

# Welcome

Thank you for selecting our office  
for your orthodontic and/or TMJ needs!  
We will strive to provide you with the best possible care.  
To help us meet all of your dental healthcare needs,  
please fill out this form completely in ink.  
If you have any questions, please ask.

## Patient Information (Confidential)

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If student, Name of school \_\_\_\_\_  Full time  Part time

Spouse or Parents' Names \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Have we treated any of your family members? \_\_\_\_\_

Family e-mail address (appointment reminders) \_\_\_\_\_

## Responsible Party

Name of Person Responsible for This Account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Name of Person Responsible for This Account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

## Dental Insurance Information

Name of Card Holder \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Ins Effective Date \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ins Co Phone \_\_\_\_\_ Lifetime Maximum \_\_\_\_\_ Percent \_\_\_\_\_

**If you have additional dental insurance, please complete the following**

Name of Card Holder \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Ins Effective Date \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ins Co Phone \_\_\_\_\_ Lifetime Maximum \_\_\_\_\_ Percent \_\_\_\_\_

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

- |   | Yes                      | No                       |  | Yes                      | No                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now?   | <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you allergic to or have any reactions to the following? |                          |                          |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?<br>If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. Novocaine)                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?<br>If yes, what medication(s) are you taking? _____              | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Phen-Fen/Redux?  | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco?  | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances?  | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you wearing contact lenses?  | <input type="checkbox"/> | <input type="checkbox"/> | Iodine   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Aspirin  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Any metals (e.g. nickel, mercury, etc.)                        | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Latex Rubber   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Other (please list) _____                                      | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 9. Women Only  |                          |                          |
|   |                          |                          | a) Are you pregnant or think you may be pregnant?              | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | b) Are you nursing?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | c) Are you taking oral contraceptives?                         | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have or have you had any of the following?

- |                       | Yes                      | No                       |                              | Yes                      | No                       |                       | Yes                      | No                       |
|-----------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| High Blood Pressure   | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease                | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains           | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack          | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker            | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded         | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever       | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur                 | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles        | <input type="checkbox"/> | <input type="checkbox"/> | Angina                       | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies   | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures     | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired             | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis          | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                | <input type="checkbox"/> | <input type="checkbox"/> | Anemia                       | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy     | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure    | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema                    | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma              | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions  | <input type="checkbox"/> | <input type="checkbox"/> | Cancer                       | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss    | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia              | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                    | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease         | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes              | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement            | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble         | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease        | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice           | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems  | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem       | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers      | <input type="checkbox"/> | <input type="checkbox"/> | Other _____           | <input type="checkbox"/> | <input type="checkbox"/> |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or responsible party \_\_\_\_\_

date \_\_\_\_\_

**Patient's Name** \_\_\_\_\_

**How long has it been since your last visit to the dentist?** \_\_\_\_\_

**Dentist's name, address, and phone #** \_\_\_\_\_

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*Please circle the appropriate answer*

**Do you make regular dental visits?** Yes No

**Have you ever had any problems or complications with any previous dental treatment?** Yes No

**If yes, please explain** \_\_\_\_\_

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**Do you clench or grind your teeth?** Yes No

**Does your jaw click or pop?** Yes No

**Have you experienced any pain or soreness in the muscles in your face or around your ears?** Yes No

**Do you get frequent headaches, neck aches, or shoulder aches?** Yes No

**Are any of your teeth loose?** Yes No

**Have you had any gum treatment or surgery?** Yes No

**If yes, please explain** \_\_\_\_\_

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**Have you had any unpleasant dental experience or is there anything about dentistry that you strongly dislike?** Yes No

**If yes, please explain** \_\_\_\_\_

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# BUBON & ASSOCIATES, ORTHODONTICS, SC

## *Wisconsin Consent*

***Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, health care operations and (b) our disclosure of the individuals dental care records to carry out treatment, payment activities and health care operations.***

### ***Section A: Individual Giving Consent***

Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

*To the Individual: Please read the following and complete the information requested*

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practice Notice: You have the right to read our privacy practices notices before you decide whether or not to sign this consent. Our notice provides a description of our treatment, payment activities, health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

### ***Section B: The Uses and Disclosures Being Authorized***

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practice Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including your insurance companies, dentist(s), doctors(s), and immediate family members. This will also allow us to inform a patient's escort of their progress. **If there is anyone else you would like to include or exclude from this grouping please list below.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up medical supplies, x-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

**Section C: Revocation**

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the contact office written below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact office: Bubon & Associates  
P: (262) 522-7447  
F: (262) 522-7448  
Address: N16 W24132 Prairie Ct.  
Suite 150  
Waukesha, WI 53188

**Patient or Guardian's Signature**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

Personal Representative's/Parent Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_