PLEASE PRINT, COMPLETE, AND BRING THIS FORM TO YOUR FIRST APPOINTMENT

DATE_____

PATIENT INFORMATION

PATIENT'S NAME _____

HOME ADDRESS _____

HOME PHONE _____ BIRTHDATE _____ SOCIAL SECURITY # _____

IF PATIENT IS A MINOR, PARENT'S OR GUARDIAN'S NAME _____

IF PATIENT IS A MINOR, PARENT'S MARITAL STATUS

SINGLE MARRIED WIDOWED DIVORCED SEPARATED

DOES THE PERSON NAMED ABOVE HAVE LEGAL CUSTODY OF CHILD? YES NO

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT OF DR. SIGODA'S? YES NO

THEIR NAME _____

PATIENT'S DENTIST _____ DATE OF LAST VISIT _____

RESPONSIBLE PARTY INFORMATION

NAME _____

HOME ADDRESS _____

HOW LONG AT THIS ADDRESS? _____ HOME PHONE _____ CELL PHONE _____

BILLING ADDRESS (IF DIFFERENT THAN HOME) _____

SOCIAL SECURITY # _____ BIRTH DATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ # YEARS EMPLOYED _____

SPOUSE'S NAME _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # _____ BIRTH DATE _____ RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION

INSURED'S NAME _____

RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY # _____

INSURANCE CO. NAME _____ INSURANCE CO. PHONE # _____

INSURED'S EMPLOYER _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

COMPLETE ADDRESS _____

PHONE # _____

HEALTH HISTORY

1. PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAMINATION_____

   ADDRESS _____ PHONE # _____

2. YOUR CURRENT PHYSICAL HEALTH IS GOOD FAIR POOR

3. HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE LAST TWO YEARS? YES NO

   IF YES, PLEASE EXPLAIN _____

4. HAVE YOU TAKEN/ ARE YOU CURRENTLY TAKING ANY PRESCRIPTION/OVER-THE-COUNTER MEDICATIONS OR DRUGS DURING THE PAST TWO YEARS? .....YES NO

   IF YES, PLEASE LIST AND GIVE DATES TAKEN _____

5. ARE YOU AWARE OF BEING ALLERGIC TO, OR HAVE YOU EVER REACTED ADVERSELY TO ANY MEDICATION OR SUBSTANCE……YES NO

6. HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

HEART ATTACK	YES	NO	ENDOCRINE OR THYROID PROBLEMS	YES	NO	ALLERGIES/HAY FEVER	YES	NO
STROKE	YES	NO	KIDNEY PROBLEMS	YES	NO	ASTHMA	YES	NO
HEART SURGERY	YES	NO	SHINGLES	YES	NO	DRUG/ALCOHOL ADDICTION	YES	NO
HEART PACEMAKER	YES	NO	COLD SORES/FEVER BLISTERS	YES	NO	PROBLEMS WITH THE IMMUNE SYSTEM	YES	NO
HEART MURMUR	YES	NO	SEVERE/FREQUENT HEADACHES	YES	NO	HIV/AIDS		
CONGENITAL HEART DEFECT	YES	NO	EPILEPSY/SEIZURES	YES	NO	HEPATITIS A (INFECTIOUS)	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	FAINTING/DIZZY SPELLS	YES	NO	HEPATITIS B	YES	NO
HIGH/LOW BLOOD PRESSURE	YES	NO	NERVOUSNESS	YES	NO	DIABETES	YES	NO
ANEMIA	YES	NO	PSYCHIATRIC TREATMENT	YES	NO	CANCER/CHEMOTHERAPY	YES	NO
HEMOPHILIA	YES	NO	MUMPS, PNEUMONIA	YES	NO	BIRTH DEFECTS OR HEREDITARY PROBLEMS	YES	NO
BRUISE EASILY	YES	NO	DIFFICULTY BREATHING	YES	NO	ARTHRITIS/RHEUMATISM	YES	NO
HOSPITALIZED FOR ANY REASON	YES	NO	ADENOIDS REMOVED	YES	NO	EATING DISORDER	YES	NO
ADDICENT/FRACTURE	YES	NO	TONSILS REMOVED	YES	NO	VENEREAL DISEASE	YES	NO
			GLAUCOMA	YES	NO			
			EMPHYSEMA	YES	NO			

7. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

LOCAL ANESTHETICS	YES	NO
ASPIRIN	YES	NO
IBUPROFEN	YES	NO
PENICILLIN/ANTIBIOTICS	YES	NO
SULFA DRUGS	YES	NO
CODEINE/NARCOTICS	YES	NO
METALS	YES	NO
LATEX/VINYL	YES	NO
ACRYLIC	YES	NO
ANIMALS	YES	NO
FOODS (SPECIFY)	YES	NO
_____		
OTHER SUBSTANCES	YES	NO
_____		

8. HAS PUBERTY BEGUN? YES NO
9. GIRLS: HAS MENSTRUATION BEGUN? YES NO
10. IS THE PATIENT PREGNANT? YES NO
11. HOW OFTEN DOES PATIENT BRUSH? _____
12. FLOSS? _____

HAVE YOU HAD ANY OF THE FOLLOWING?

PRIMARY (BABY) TEETH REMOVED THAT WERE NOT LOOSE	YES	NO
SUPERNUMERARY (EXTRA) OR CONTENITALLY MISSING TEETH	YES	NO
TEETH SENSITIVE TO HOT/COLD; TEETH THROB OR ACHE	YES	NO
JAW FRACTURES, CYSTS OR MOUTH INFECTIONS	YES	NO
"DEAD" TEETH, OR ROOT CANALS TREATED	YES	NO
BLEEDING GUMS, BAD TASTE, OR MOUTH ODOR	YES	NO
THUMB, FINGER, OR SUCKING HABIT? UNTIL WHAT AGE _____	YES	NO
ABNORMAL SWALLOWING HABIT (TONGUE THRUSTING)	YES	NO
HISTORY OF SPEECH PROBLEMS	YES	NO
MOUTH BREATHING HABIT/SNORING/DIFFICULTY BREATHING	YES	NO
TOOTH GRINDING OR JAW CLENCHING	YES	NO
ANY PAIN IN JAW OR RINGING IN EARS	YES	NO
DIFFICULTY ENCOUNTERED IN CHEWING OR JAW OPENING	YES	NO
ANY TEETH IRRITATING CHEEK, LIP, TONGUE OR PALATE	YES	NO
CONCERNED ABOUT SPACED, CROOKED OR PROTRUDING TEETH	YES	NO
AWARE OF CONCERNED ABOUT UNDER OR OVER DEVELOPED JAW	YES	NO
HAVE YOU BEEN EVALUATED FOR ORTHODONTIC TREATMENT	YES	NO
ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT	YES	NO
EVER HAD A PRIOR ORTHODONTIC EXAMINATION OR TREATMENT	YES	NO

WHAT IS YOUR PRIMARY CONCERN (WHY ARE YOU HERE)? _____

WHO MAY WE THANK YOU REFERRING YOU/HOW DID YOU SELECT OUR OFFICE? _____

I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. I WILL NOT HOLD DR. SIGODA OR ANY MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM. IF THERE ARE ANY CHANGES LATER TO THIS HISTORY RECORD OR MEDICAL /DENTAL STATUS, I WILL INFORM THE STAFF.

RELATIONSHIP TO PATIENT _____

PRINTED NAME: _____

SIGNED: _____ DATE SIGNED: _____

Medical Release

I hereby authorize Sigoda Orthodontics to release medical or incidental information that may be necessary for medical care or to process medical insurance claims for which payment is assigned to the provider.

_____

Patient/Parent or Guardian Name Printed

_____ _____

Patient/Parent or Guardian Name Signature Date

****

Please provide us with a valid email address for newsletters, appointment reminders, and bad weather closings.

E-mail:_____ Initial: _____

****

I authorize that Sigoda Orthodontics may speak with the following family member (s) regarding any medical and billing information.

_____ _____ _____

Name of family member Relationship to Patient Phone #

_____ _____ _____

Name of family member Relationship to Patient Phone #

Victor J. Sigoda, DDS, PA
7652 Eldorado Parkway
McKinney, TX 75070-5652
Office: 972-542-2112
Fax: 972-542-9242

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);*
- *Obtaining payment from third party payers (e.g. my insurance company);*
- *The day-to-day healthcare operations of your practice*

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Victor J. Sigoda, DDS, PA
7652 Eldorado Parkway
McKinney, TX 75070-5652
Office: 972-542-2112
Fax: 972-542-9242