Aloha ORTHODONTICS
Pamela Regimbal, D.D.S., PLLC

8266 Jupiter Drive
Mechanicsville, VA 23116
Phone: 804.746.7720
Fax: 804.200.4349

www.alohabraces.us

Patient Information

All About You

Name:_____
Last First MI
I prefer to be called:_____
Male/ Female Birthdate:____/____/_____ Age:_____
Single Married Divorced Widowed Separated
Home: # ( ) _____Cell: # ( )_____
Home Address:_____
City:_____State:_____Zip:_____
Occupation:_____
Employer: _____
Work: # ( )_____Ext:_____
Work Address: _____
City:_____State:_____Zip:_____
Where/when is the best time to reach you?:_____
Whom may we thank for referring you?:_____
Emergency Contact:_____
Phone: # ( )_____

Other Contact Information

His/Her Name:_____
Relation:_____
Home: # ( ) _____Cell: # ( )_____

Dental History

General Dentist:_____
Date of Last Exam:_____
Your current dental health is: Good Fair Poor
What are the main concerns that you would like orthodontics to accomplish?_____

Have you ever had or been evaluated for orthodontic treatment?	Y N
Have you ever had a serious/difficult problem with any previous dental work?	Y N
Have there ever been any injuries to the face, mouth, teeth or chin?	Y N
Do you have any missing or extra permanent teeth?	Y N
Do you generally breathe through your mouth?	Y N
Do you brush your daily?	Y N
Do you floss your teeth daily?	Y N
Do your gums ever bleed?	Y N
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?	Y N

Medical History

Your current dental health is: Good Fair Poor
Are you currently under the care of a physician? Y N
Please explain: _____
_____
Physician's Name: _____
Are you taking prescription/over-the-counter drugs? Y N
Please list each one: _____
_____

Have you ever had any of the following?

Abnormal Bleeding	Y	N
Anemia/Radiation Treatment	Y	N
Artificial Bones/Joints/Valves	Y	N
Asthma	Y	N
Arthritis	Y	N
Blood Transfusion	Y	N
Cancer/Chemotherapy	Y	N
Congenital Heart Defects	Y	N
Diabetes	Y	N
Difficulty Breathing	Y	N
Emphysema	Y	N
Epilepsy/Seizures/Fainting	Y	N
Glaucoma	Y	N
Hearing Impairment	Y	N
Hemophilia	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Heart Surgery/Pacemaker	Y	N
Hepatitis	Y	N
High/Low Blood Pressure	Y	N
HIV+/AIDS	Y	N
Kidney/Liver Problems	Y	N
Rheumatic/Scarlet Fever	Y	N
Sinus Problems	Y	N
Severe/Frequent Headaches	Y	N
Tuberculosis	Y	N
Are you Pregnant?	Y	N

Please list any serious medical condition(s) that you have ever had:
_____
Are you allergic to any of the following? (Please Circle)

Aspirin	Erythromycin	Penicillin
Codeine	Latex	Tetracycline
Dental Anesthetics	Metals/Plastics	Other: _____

I understand that the information I have provided is correct to the best of my knowledge and that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

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Account & Insurance Information

PATIENT NAME: _____ DATE: _____

BIRTHDATE: _____

RESPONSIBLE PARTY

Name: _____

Relation: _____ SS#: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home #: ( )_____ Email: _____

Employer: _____ Work #: ( ) _____

PRIMARY DENTAL INSURANCE

Policy Holder: _____

Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: ( )_____ Cell #: ( ) _____

SS#: _____ Birthdate: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: ( )_____ Ext: _____

Insurance Company: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Group #: _____

Plan #: _____

Subscriber ID #: _____

Phone #: _____

SECONDARY DENTAL INSURANCE

Policy Holder: _____

Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: ( )_____ Cell #: ( )_____

SS#: _____ Birthdate: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: ( )_____ Ext. _____

Insurance Company: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Group #: _____

Plan #: _____

Subscriber ID #: _____

Phone #: _____

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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 the 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 restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, 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: _____

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Permission To Discuss Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

OR

_____ Initial here if you do not wish to release you/or your child's protected information to anyone.

This authorization permits Aloha Orthodontics to use and/or disclose the following individually identifiable health information about myself/or my child. It is understood that Aloha Orthodontics will only disclose information relevant to current treatment.

Signature: _____ Date: _____

Relationship to Patient: _____

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What's Most Important to You?

We consider your satisfaction to be of the utmost importance, and this starts by personalizing your orthodontic experience. Please review the treatment aspects below that our skilled team of professionals can deliver using several state-of-the-art technologies.

(Please rank your top three treatment aspects from 1 to 3)

_____ **Aesthetics**: I would prefer it if people don't notice that I'm in orthodontic treatment.

_____ **Colors**: I want to have fun displaying different colors (on holidays, for sports teams, etc.).

_____ **Comfort**: I want the highest degree of comfort possible during treatment.

_____ **Length of time in Treatment**: I want to have a beautiful smile as quickly as possible.

_____ **Visit Frequency**: I want to come to the orthodontist as few times as possible.

_____ **Appointment Length**: I want to sit in the chair for short periods during adjustment appointments.

_____ **Schedule**: I'd like appointments to accommodate my own schedule (before or after school/work).

_____ **Punctuality**: I want to be seen on time for adjustment appointments.

_____ **Treatment Cost**: The down payment and monthly payment are major considerations.

_____ **Other**: _____