Amazing Smiles
PAUL HWANG D.D.S., M.S.
ORTHODONTICS

PATIENT HEALTH QUESTIONNAIRE FOR: _____

Please complete both pages of this health questionnaire as fully and completely as possible, writing in any other information you feel would be helpful. Your confidentiality will be respected.

Have you been evaluated by another orthodontist? _____

Emergency Contact (Full Name & Phone Number) _____

Address _____

Phone _____

Email _____

Insured's Name _____

Insured's Date of Birth _____

Insured's S.S.# _____

Insured's Employer _____

Dental Insurance Co. _____

__ Crowded teeth
__ "Buck teeth"
__ Prominent jaw
__ Spacing between teeth
__ Missing teeth
__ Mouth too small
__ Irregular teeth
__ Ears ring / stuffy
__ Neck pain
__ Irregular facial appearance
__ Over bite
__ Receded jaw
__ Gummy smile
__ Gum disease / recession
__ Jaw dysfunction
__ Clicking jaw joint
__ Protrusion of teeth
__ Headache / face pain
__ Jaw pain
__ Other _____

FAMILY MEMBERS WITH SIMILAR CONDITION(S)

__ Father __ Mother __ Brother __ Sister

__ Other _____

PATIENT'S CURRENT PHYSICAL HEALTH

__ Excellent __ Good __ Fair __ Poor

KNOWN OR SUSPECTED ALLERGIES

__ Antibiotics _____
__ Pain pills _____
__ Foods _____
__ Environmental allergies _____
__ None

_____ **PLEASE INITIAL**

CONDITIONS THE PATIENT HAS OR HAS HAD

__ AIDS
__ Allergies
__ Asthma
__ Autoimmune disorders
__ Blood disease
__ High blood pressure
__ Low blood pressure
__ Bone disorders
__ Cancer
__ Diabetes
__ Dizziness
__ Eating disorders
__ Endocrine problems
__ Emotional problems
__ Female problems
__ HIV positive status
__ Hepatitis
__ Heart disease
__ Heart murmur
__ Hearing disorder
__ Kidney disease
__ Rheumatic fever
__ Ringing of the ears
__ Sleep disturbance
__ History of trauma:
__ Teeth__ Face __ Jaws __ Head
__ None of the above

_____ **PLEASE INITIAL**

CURRENT MEDICATIONS

__ Heart pills
__ Antibiotics _____
__ Diet pills
__ Pain pills _____
__ Vitamins
__ Birth control pills
__ Muscle relaxants
__ Insulin
__ Other _____
__ None

____ **PLEASE INTITIAL**

PRIMARY BREATHING PATTERN

__ Mouth __ Nose
__ Depends on _____

DOES THE PATIENT SNORE WHEN SLEEPING?

__ Yes __ No
__ Sometimes _____

DIFFICULTY CHEWING?

__ No
If yes, please indicate below which apply:
__ Teeth don't meet well
__ Pain when chewing
__ Other _____

CHECK ALL THAT APPLY

__ Frequent sore throat / tonsillitis
__ Speech problems
__ Pain in the RIGHT jaw joint
__ Pain in the LEFT jaw joint
__ Clicking / popping in the RIGHT jaw joint
__ Clicking / popping in the LEFT jaw joint
__ Previous thumb / finger sucking habit
__ Lip biting / sucking habit
__ Grind teeth
__ Clench jaws
__ Tongue thrust when swallowing

HAS (CHILD) PATIENT REACHED PUBERTY

__ Yes, approximate date _____
__ No

FREQUENCY OF DENTAL CHECKUPS

__ Once per year
__ Twice per year
__ More than twice a year
__ Emergencies only
__ Never

PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

__ Wants treatment
__ Only if necessary
__ Unwilling
__ Will cooperate if treatment is needed
__ Uncooperative

ORTHODONTIC EXAM PROMPTED BY

__ Patient __ Mother __ Spouse
__ Dentist __ Father __ Sibling
__ Doctor __ Friend __ Other

MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?

If yes, please describe:

_____
_____
_____
_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers.
Conduct normal health & dental care operations such as quality assessments and physicians certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices.* From time to time and that I may contact Dental Health Associates at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. In addition, I understand you are not required to agree to my requested restrictions.

PATIENT NAME (PRINT) _____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

DATE _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THE *NOTICE OF PRIVACY PRACTICES,* BUT WAS UNABLE TO DO SO AS DESCRIBED BELOW:

DATE _____ INITIAL _____

REASON _____