BLACKBURN FAMILY ORTHODONTICS

Dr. James Blackburn
Blackburn Family Orthodontics

patient information

Date: _____ Patient's Name: _____

Nickname: _____ Birthday: _____ Sex: M / F

If minor, name of Parent/Guardian: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email Address: _____

How did you hear about our office? _____

responsible/insured party information

Name: _____ Relationship to Patient: _____

Birthday: _____ Insured's Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Insurance Company: _____

Group No.: _____ ID: _____ Phone No. _____

Insurance Co. Address: _____

fun facts for kids (and adults)

School: _____ Favorite hobby: _____

Favorite food: _____ Favorite sport: _____

dental history

Dentist: _____ Date of last visit: _____

What concerns you most about your teeth? _____

_____

Yes No Have you ever lost or chipped any permanent teeth? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

BLACKBURN FAMILY ORTHODONTICS

Dr. James Blackburn
Blackburn Family Orthodontics

medical history

Physician: _____ Date of Last Visit: _____

Please circle Yes or No (If Yes, please explain). Parents/Guardians please respond for minors.

Yes No Are you taking any medications_____

Yes No Do you have any allergies? _____

Yes No Do you have a history of a major illness/operation? _____

Yes No Does your physician recommend pre-medicating with antibiotics_____

Yes No Female Patients only: Are you pregnant? _____

Yes No Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Epilepsy	Kidney problems
Anemia	Gastrointestinal Disorders	Nervous Disorders
Arthritis	Heart Problems	Pneumonia
Asthma or Hayfever	Hepatitis/Liver problems	Radiation/Chemotherapy
Bone Disorders	Herpes	Rheumatic Fever
Congenital Heart Defect	High Blood Pressure	Tuberculosis
Diabetes	HIV / AIDS	Tumor or Cancer

I have read and understand the above questions. I will not hold my orthodontist 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 to the medical or dental history, I will so inform this practice.

Signature: _____ Date: _____

James Blackburn DDS, MSD

ACKNOWLEDGEMENT OF RECEIPT 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 Patient's 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
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____