Date _____

Welcome to ibraces by Dr. Gracie Sturdivant Board Certified Orthodontist

A B C D

All information provided will remain confidential

PATIENT INFORMATION

Patient's Name _____ Birth Date _____ Age_____
First Middle Last

Physical Address _____
Street City State Zip Code

Primary Phone _____ Secondary Phone _____ Email_____

General Dentist_____ Grade/School _____ Siblings Name & DOB_____

How did you hear about our office? _____ Preferred contact method: Text ☐ Email ☐ Phone ☐

PRIMARY RESPONSIBLE PARTY INFORMATION

Relationship To Patient ☐ Father ☐ Mother ☐ _____
Other - please explain

Name _____
First Middle Last

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Physical Address _____
Street

_____
City State Zip Code

Mailing Address _____
(if different from above) Street / PO Box

_____
City State Zip Code

How long at current address? _____ years _____ months

Do you currently Own ☐ or Rent ☐

Home Phone _____ Work Phone_____

Social Security #_____ Birthdate_____

E-mail _____Occupation _____

SECONDARY RESPONSIBLE PARTY INFORMATION

Relationship To Patient ☐ Father ☐ Mother ☐ _____
Other - please explain

Name _____
First Middle Last

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Physical Address _____
Street

_____
City State Zip Code

Mailing Address _____
(if different from above) Street / PO Box

_____
City State Zip Code

How long at current address? _____ years _____ months

Do you currently Own ☐ or Rent ☐

Home Phone _____ Work Phone_____

Social Security #_____ Birthdate_____

E-mail _____Occupation _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Policy Holder's Name _____

DOB _____ Social Security # _____

Insurance Company _____

Group # _____ MemberID # _____

Insurance Co. Phone _____

Employer_____ # of Years _____

Secondary Dental Insurance

Policy Holder's Name _____

DOB _____ Social Security # _____

Insurance Company _____

Group # _____ MemberID # _____

Insurance Co. Phone _____

Employer_____ # of Years _____

EMERGENCY CONTACT INFORMATION

Name of Nearest Relative not living with you _____

Address _____ Phone _____
Street City State Zip Code

I understand that where appropriate, credit bureau reports may be obtained.

Sign Here _____
Signature of parent or guardian

Information Updates

Date	Initial
_____	_____
_____	_____

Welcome to ibraces by Dr. Gracie Sturdivant Board Certified Orthodontist

All information provided will remain confidential

PATIENT DENTAL HISTORY INFORMATION

Has the patient seen a dentist in the last 6 months?..... ☐Y ☐ N
Date of last cleaning _____
Any pain, clicking or discomfort in the ears?..... ☐Y ☐N
Any serious injury to the patient's mouth, face, teeth ?…….. ☐Y ☐N
Have you been informed of missing or extra permanent teeth?..... ☐Y ☐N
Are you aware of any gum problems?..... ☐Y ☐N
Has a physician or dentist advised antibiotics before a dental exam?.. ☐Y ☐N
Have the patient's tonsils or adenoids been removed?..... ☐Y ☐N
Has the patient been examined by an orthodontist before?..... ☐Y ☐N
If yes, when? _____
Have other members of the family had orthodontic treatment?..... ☐Y ☐N
If yes, were you happy with the results?..... ☐Y ☐N
If no, why not?
_____
In your own words, what is the orthodontic problem?
_____
_____
What would you like orthodontic treatment to accomplish?
_____
_____ ☐Y ☐N
Is the patient / are you happy with his / her smile?..... ☐Y ☐N
Is the patient comfortable with the idea of wearing braces?..... ☐Y ☐N

Has the patient ever had the following habits?

Cheek, tongue or lip chewing?..... ☐Y ☐N
Sucks thumbs / fingers?..... ☐Y ☐N
Mouth breathing?..... ☐Y ☐N
Clenches teeth?..... ☐Y ☐N
Grinds teeth?..... ☐Y ☐N
Tongue thrusting?..... ☐Y ☐N
Speech Problems? …… ☐Y ☐N

PATIENT MEDICAL HISTORY INFORMATION

Heart Disease?	☐Y	☐N	Hearing Problems?	☐Y	☐N
Heart Surgery?	☐Y	☐N	HIV Positive?	☐Y	☐N
Heart Murmur?	☐Y	☐N	AIDS?	☐Y	☐N
Rheumatic Fever?	☐Y	☐N	High Blood Pressure?	☐Y	☐N
Yellow Fever?	☐Y	☐N	Low Blood Pressure?	☐Y	☐N
Scarlet Fever?	☐Y	☐N	Tumors or Cancer?	☐Y	☐N
Rheumatism?	☐Y	☐N	Respiratory Disease?	☐Y	☐N
Arthritis?	☐Y	☐N	Measles/Mumps?	☐Y	☐N
Joint Replacement?	☐Y	☐N	Chicken Pox?	☐Y	☐N
Blood Disease?	☐Y	☐N	Polio?	☐Y	☐N
Liver Disease?	☐Y	☐N	Nervous/Emotional?	☐Y	☐N
Venereal Disease?	☐Y	☐N	Diabetes?	☐Y	☐N
Tuberculosis?	☐Y	☐N	Anemia?	☐Y	☐N
Thyroid Disease?	☐Y	☐N	Hemophilia?	☐Y	☐N
Kidney Disease?	☐Y	☐N	Emphysema?	☐Y	☐N
Fainting/Dizziness?	☐Y	☐N	Epilepsy?	☐Y	☐N
Stomach Disease?	☐Y	☐N	Blood Transfusions?	☐Y	☐N
Intestinal Disease?	☐Y	☐N	Asthma / Hay Fever?	☐Y	☐N
Bone Disease?	☐Y	☐N	Broken Bones?	☐Y	☐N
Endocrine Disease?	☐Y	☐N	Prolonged Bleeding?	☐Y	☐N
Mononucleosis?	☐Y	☐N	Yellow Jaundice?	☐Y	☐N
Hepatitis?	☐Y	☐N	Chemical Therapy?	☐Y	☐N
Fever Blisters?	☐Y	☐N	Radiation Therapy?	☐Y	☐N

Is the Patient:
Under Medical Care?..... ☐Y ☐N
Taking Medication(s)?..... ☐Y ☐N
Please list_____
Allergies?..... ☐Y ☐N
Please list_____
Addicted to Drugs?..... ☐Y ☐N
Pregnant at this time?..... ☐Y ☐N
Currently Smoking?..... ☐Y ☐N
Normal Height / Weight?..... ☐Y ☐N
Past Puberty?..... ☐Y ☐N

Has the patient had a physical this year? ☐Y ☐ N
Are you aware of any other disease, condition, or problem not listed above that we should know about? ☐Y ☐ N
If yes, please explain:_____
Have you ever taken bisphosphonate drugs(Fosamax, Boniva, etc. used to treat osteoporosis or multiple myeloma)? ☐ Y ☐ N

I have reviewed the patient's dental and medical history and confirm that it is current and complete. Dr's. Initials_____

Request of Release of Records

I, _____ hereby request and give my permission to Gracie Sturdivant, D.D.S., P.A. to provide Dentists, Medical Doctors, and / or insurance with any and all information he / she may request with respect to the orthodontic care of _____. Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental records and medical records. I acknowledge receipt of the Notice of Privacy Practices of this office.

Sign Here _____ Date _____
Signature of Patient, Parent, Legal Guardian or Custodian (if patient under 18)

Sign Here _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

OFFICE USE ONLY
Additional medical, dental or orthodontic concerns here:

_____
_____
_____

☐Scanned ☐Correspondence Letter ☐Informed Consent ☐Status Update Patient# _____

ibraces
by Dr. Gracie Sturdivant
Board Certified Orthodontist

PRIVACY NOTICE

Patient Name:_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Sign Here _____ _____

Patient or Responsible Party Date

28214 IH-10 West
Suite 101
Fair Oaks, TX 78006
210-538-2727