Finkelmeier
ORTHODONTICS

Hi,

Thank you for selecting Finkelmeier Orthodontics for your orthodontic treatment needs!

Your first visit will involve a comprehensive orthodontic examination, including any necessary orthodontic records. If treatment is recommended, we will have plenty of time to discuss the treatment plan, the estimated treatment time and the fees associated with this service.

If you have insurance that covers orthodontic treatment, please make sure we have that information before the day of your examination so we can give you an estimated benefit during the appointment.

We have included some important forms with this letter. Please complete them ahead of time and bring them with you to your next appointment.

We are looking forward to a relaxed and pleasant visit with you. Please call or visit our website at www.finkelmeierorthodontics.com for directions or for more information about our practice. We will see you soon.

Sincerely yours,

The Doctor and Staff of
Finkelmeier Orthodontics

Finkelmeier Orthodontics
Dr. Brett Finkelmeier, DDS, MS
912 S. Rangeline Rd. #120, Carmel, IN 46032
317-993-3789 www.finkelmeierorthodontics.com

Finkelmeier ORTHODONTICS

PATIENT INFORMATION - ADULT

Date_____

Title_____ Legal Name_____

Preferred Name_____ DOB_____ Gender_____

E-Mail Address_____ Marital Status/Spouse's Name_____

Address_____

Phone 1 _____ Phone 2_____

Employer_____ Occupation_____

Hobbies/Interests_____

Referred By_____ General Dentist_____

Past or Present Family Members in Treatment _____

Have you Consulted an Orthodontist Before?_____

PRIMARY INSURANCE INFORMATION

Subscriber's Name_____ DOB_____

Address_____ Phone_____

Employer_____

Insurance Company_____ Phone_____

Group Number_____ Subscriber ID/SS#_____

SECONDARY INSURANCE INFORMATION

Subscriber's Name_____ DOB_____

Address_____ Phone_____

Employer_____

Insurance Company_____ Phone_____

Group Number_____ Subscriber ID/SS#_____

Signature_____ Date_____
(Parent/Legal Guardian)

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MEDICAL HISTORY

Patient's Name _____ Date _____

Dentist's Name _____ Date of Last Dental Exam _____

Physician's Name _____ Date of Last Physical Exam _____

Allergies or reactions to any of the following:

Y _ N _ Aspirin, Ibuprofen or Tylenol
Y _ N _ Barbiturates
Y _ N _ Codeine or other narcotics
Y _ N _ Latex
Y _ N _ Local anesthetics
Y _ N _ Metals
Y _ N _ Penicillin or other antibiotics
Y _ N _ Plastic or vinyl
Y _ N _ Sedatives
Y _ N _ Sleeping pills
Y _ N _ Sulfa drugs
Y _ N _ Other _____

Medications:

Please list medications, nutrient supplements, herbal medications & non-prescription medicines currently being taken:

Medication	Taken For

Now or in the past, has the patient had:

Y _ N _ Adenoids or tonsils removed
Y _ N _ Arteriosclerosis (hardening of the arteries)
Y _ N _ Asthma, hay fever, sinus trouble or hives
Y _ N _ Autoimmune disorders or immune system problems
Y _ N _ Bleeding or bruising easily
Y _ N _ High or low blood pressure – please circle
Y _ N _ Cancer, tumor, chemotherapy or radiation treatment
Y _ N _ Chronic fatigue
Y _ N _ Current pregnancy
Y _ N _ Depression or other mental health disturbance
Y _ N _ Diabetes
Y _ N _ Dizziness
Y _ N _ Epilepsy or other seizure disorder
Y _ N _ Fibromyalgia
Y _ N _ General anesthesia
Y _ N _ Hearing impairment
Y _ N _ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y _ N _ Frequent coughs, colds or sore throats
Y _ N _ Hemophilia
Y _ N _ Hepatitis, AIDS or HIV positive
Y _ N _ Injury to face, neck, mouth or teeth – please circle
Y _ N _ Insomnia
Y _ N _ Jaw joint surgery
Y _ N _ Kidney or liver problems
Y _ N _ Meniere's disease
Y _ N _ Multiple sclerosis
Y _ N _ Muscular dystrophy
Y _ N _ Nighttime breathing problems (snoring or sleep apnea)
Y _ N _ Nervousness
Y _ N _ Neuralgia
Y _ N _ Osteoarthritis (stiff or swollen joints)
Y _ N _ Osteoporosis
Y _ N _ Parkinson's disease
Y _ N _ Prior orthodontic treatment
Y _ N _ Psychiatric care
Y _ N _ Rheumatic fever
Y _ N _ Rheumatoid arthritis
Y _ N _ Scarlet fever
Y _ N _ Skin disorder
Y _ N _ Speech difficulties
Y _ N _ Stroke or heart attack
Y _ N _ Tuberculosis
Y _ N _ Wisdom teeth extraction
Y _ N _ Birth defects or hereditary problems
Y _ N _ Endocrine or thyroid problems
Y _ N _ Stomach ulcer or hyperacidity
Y _ N _ Polio, mononucleosis or pneumonia
Y _ N _ Vision problems
Y _ N _ Loss of weight recently, poor appetite
Y _ N _ Eating disorder (anorexia or bulimia)
Y _ N _ Chest pain, shortness of breath or swelling ankles
Y _ N _ Frequent or severe headaches
Y _ N _ Other condition

Emergency Contact _____ Relationship _____ Phone # _____

Patient/Parent Signature _____ Today's Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient's Legal Name _____

Section B: To the Patient – Please Read these Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request with this Consent. We encourage you to read it carefully and completely before signing this consent.

Office Procedures: As a part of the practice procedures our doctors reserve the right to use patient photographs, x-rays, videos and other photographic reproductions for the purpose of professional academic education and practice promotion, including use on website, brochures and social media sites.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will make available upon request a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person:	Nicole Finkelmeier
Telephone:	317-993-3789
Email:	info@finkelmeierorthodontics.com
Address:	912 S. Rangeline Rd., Suite 120 Carmel, IN 46032

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Section C: Signature

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient/Parent Signature _____ Today's Date _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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