WILSON ORTHODONTICS

Dr. Josh Wilson, DDS, MDS

Hello,

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

Your visit will involve a comprehensive orthodontic examination. If treatment is recommended, we will proceed with orthodontic records to develop an individualized treatment plan. We will then have a consultation where 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 as soon as possible so we can give you an estimated benefit.

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.DrWilsonOrtho.com for directions or for more information about our practice. We will see you soon.

Sincerely yours,

The Doctor and Staff of
Wilson Orthodontics

Wilson Orthodontics
Dr. Josh Wilson, DDS, MDS
806 Hatcher Lane
Columbia, TN 38401
931.381.2700
www.DrWilsonOrtho.com

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Patient Information – Youth

Date_____

Patient's Legal Name_____ Preferred Name_____

DOB_____ Gender_____ School/Grade_____

Hobbies/Interests_____

Referred By_____ General Dentist_____

Past or Present Family Members in Treatment_____

Have you consulted an Orthodontist before?_____

Parent/Guardian Information

Mother's Name_____ DOB_____

E-Mail Address_____ Marital Status/Spouse's Name_____

Address_____ Phone_____

Employer_____ Occupation_____

Father's Name_____ DOB_____

E-Mail Address_____ Marital Status/Spouse's Name_____

Address_____ Phone_____

Employer_____ Occupation_____

Insurance Information

Subscriber's Name_____ DOB_____

Address_____ Phone_____

Employer_____

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 --- Barbituates
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
Other_____

Medications:

Please list medications, nutrient supplements, herbal medications and 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 --- Muscular dystrophy
Y – N --- Nighttime breathing problems
Y – N --- Nervousness
Y – N --- Neuralgia
Y – N --- Osteoarthritis
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 --- Heart problems (murmur, irregular beat, 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 --- 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/appetite
Y – N --- Eating disorder (anorexia/bulimia)
Y – N --- Chest pain, shortness of breath
Y – N --- Frequent or severe headaches
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 doctor reserves 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 our office:

806 Hatcher Lane
Columbia, TN 38401
931.381.2700

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 _____

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