Dr. Markus Niepraschk DDS MS
32 Mill Creek Road, Suite 107
Charlottesville, VA 22902
434-977-WIRE (9473)
434-977-9417 FAX

We would like to welcome you to our office. Please complete both sides of this form. All information is confidential.

PATIENT INFORMATION

Patient's Name: _____

Address: _____City:_____State:_____ZIP:_____

Birth Date: _____ Age: _____

How did you hear about our office? _____

IF UNDER 18

Mother's Name _____Father's Name_____

School: _____ Grade: _____

Hobbies: _____ Siblings: _____

Has any family member had braces before? If so, who? _____

RESPONSIBLE PARTY -Who will be responsible for financial account(s)?

First Name: _____ Last Name: _____ MI: _____ Marital Status_____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone:_____

Relation to Patient: _____ Social Security #: _____

Employer: _____ Occupation: _____ No. Years employed: ____

Employer's Address:_____Phone:_____

DO YOU HAVE ORTHODONTIC INSURANCE?

Insurance Company: _____ Name of Insured: _____

Birth Date: _____Social Security #: _____ Relation to Patient: _____

Group Number: _____Insurance ID#_____

Insurance Co. Address and Phone Number: _____

Insured Employer_____

DENTAL/MEDICAL HISTORY

Dentist's Name: _____ Phone: _____ Date of last cleaning? _____

Physician's Name: _____ Phone: _____ Date of last visit? _____

Has an orthodontist previously been consulted? NO YES If so, when?_____

What concerns would you like Orthodontics to accomplish? _____

Is the patient currently under a physician's care? NO YES

If yes, for what reason? _____

Have the tonsils and adenoids been removed? NO YES

Has the patient ever sucked a thumb or finger? NO YES

Until what age? _____

Is the patient currently taking any drugs/medications? NO YES

If yes please list: _____

Does the patient have any allergies? NO YES

If yes please list: _____

Has there ever been an adverse reaction to latex or nickel? NO YES

Does the patient need antibiotics before seeing the dentist? NO YES

Please circle any of the following conditions that the patient has had or now has:

Congenital Heart Lesions Anemia Epilepsy/Seizures Jaw/Facial Injuries

Heart Murmur HIV/AIDS Fainting Spells Dental/Tooth Injuries

Rheumatic Fever Hepatitis Asthma Frequent Headaches

Tuberculosis Kidney Problems Mouth Breathing Clenching/Grinding Of Teeth

Persistent Cough Liver Problems Speech Problems Ringing In The Ears

Abnormal Bleeding Stomach Ulcers Canker Sores Sinus Trouble

High/Low Blood Pressure Mental Disorders Jaw Locking Smoke/Chew tobacco

Diabetes Arthritis Sore Facial Muscles Currently Pregnant

Do you have any medical or dental problems not listed above? ____ Yes ____ No

Please explain_____

The information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status.

I hereby give South Side Orthodontics permission to confirm appointments using the phone number(s) provided, including leaving messages.

_____ _____

Signature Patient, Parent or Guardian Date

How do you wish to be notified to confirm appointments?

Phone_____Home Work Cell

E-mail_____

Privacy Acknowledgement for
Mill Creek Orthodontics
32 Mill Creek Dr., Suite 107
Charlottesville, VA 22902

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). 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 orthodontic 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.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that South Side Orthodontics has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time at the address above to obtain a current copy of the Notice of Private 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

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Office Use Only

I attempted to obtain the patient's signature of acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: