William V. Gierie, DDS, MS, PA.
Adult form
700 Military Cutoff Rd. • Suite 100 • Wilmington, NC 28405
(910) 256-8590 Office (910) 256-1078 Fax

What brought you to see us? Why are you here? _____
Referred By_____ Date _____
Patient's Name_____ Preferred Name _____
Birth date _____ Age_____ Sex_____ Patient's Dentist_____
Date of last dental cleaning _____ Date of last X-rays taken _____
Patient SSN _____ Physician _____
Home Address_____ Home Phone _____
_____ Work Phone _____
Email Address _____ Mobile Phone _____
Occupation _____ Employed By _____
Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widow(er) _____
Spouse's name (if applicable) _____
Occupation _____ Employed By _____
Name of any family members we have seen _____
Names and Ages of Children in the family _____
Person(s) responsible for Payment of Account _____
Address and Relationship to Patient (if different than above) _____
_____

MEDICAL HISTORY

Are you in good health?_____ Do you have any history of major illness? _____
Please list (give dates) _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

HEART TROUBLE	☐	HIV/AIDS	☐	ATTENTION DEFICIT	☐	LIVER INVOLVMENT	☐
MITRAL VALVE PRO	☐	ANEMIA	☐	KIDNEY PROBLEMS	☐	HEPATITIS	☐
HEART MURMUR	☐	EPILEPSY	☐	ENDOCRINE PROBLEMS	☐	BLOOD DISORDERS	☐
RHEUMATIC FEVER	☐	ASTHMA	☐	PROLONGED BLEEDING	☐	DIABETES	☐
PNEUMONIA	☐	FAINTING OR DIZZYNESS	☐	TUBERCULOSIS	☐	OTHER _____	☐

Do you have a tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores _____
Have tonsils and adenoids been removed? _____ What Age? _____ List any drugs or medications now being taken and reason. _____
LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

DENTAL HISTORY

Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date _____
_____ Has the patient ever sucked a thumb or fingers? **Y /N** Age _____
Do you have any speech problems? **Y / N**
Any pain in or near the ears? **Y / N**
Have you been informed of any missing or extra permanent teeth? **Y/ N**
Has an orthodontist been consulted previously? **Y / N**
Have you ever had orthodontic treatment before? **Y / N** If yes when? _____
List any musical instruments played _____
Interests or hobbies_____

Signature _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Gierie Orthodontics _____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

Gierie Orthodontics

Dr. William V. Gierie, DDS, MS, PA
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Wilmington, NC 28405
(910)256-8590

Acknowledgement of Receipt of Notice of Privacy Practices

*Our Notice of Privacy Practices is posted on our website and is also available at the front desk in the black notebook. We can also provide you a copy for your records by request.

Patient Name and Address:

_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

_____

For Office Use Only

_____

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed and a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

_____

- Other:

_____

Prepared By _____

Signature _____

Date _____