



Hi,

Thank you for selecting FMY Orthodontics to care for your orthodontic treatment needs. We are looking forward to seeing you soon.

Your upcoming visit will involve taking orthodontic models to submit to your insurance company for approval or denial.

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.fmyortho.com](http://www.fmyortho.com) for directions or for more information about our practice. We will see you soon.

Sincerely yours,

The Doctors & Staff of  
FMY Orthodontics

**FMY Orthodontics**

Drs. Merwin, Miller and Thomas

Jackson ♦ Martin ♦ Dyersburg ♦ Henderson ♦ Bolivar ♦ Brownsville  
(731)668-8922 1-800-548-5303 [www.fmyortho.com](http://www.fmyortho.com)



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

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Patient/Parent Signature \_\_\_\_\_ Today's Date \_\_\_\_\_



## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### Section A: Patient Giving Consent

Patient's Legal Name \_\_\_\_\_

Office Use Only

### 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.

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: Cynthia Pham  
Telephone: 731-668-8922 ext 111  
Email: cpham@fmyortho.com  
Address: 190 Murray Guard Dr  
Jackson, TN 38305

**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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