Hi,

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

Your 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.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

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

Office Use Only

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.

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