WELCOME TO OUR OFFICE

WHO ARE WE SEEING TODAY?

Patient's Full Legal Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Patient Email: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Full Name: _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Primary Phone: _____ Secondary Phone: _____

How would you prefer to be contacted? Phone Call, Text, or Email? _____ Relationship to Patient: _____

How did you find out about us? _____

Dentist: _____ Last cleaning/ Check-Up: _____

INSURANCE INFORMATION

Insured's Name: _____ Date of Birth: _____ Social Security: _____

Employer Name: _____ Insurance Company: _____

Group Number: _____ Policy Number: _____ Effective Date: _____

Relationship to Subscriber: _____ Phone Number: _____

Insurance Co. Address: _____

SECONDARY INSURANCE INFORMATION

Insured's Name: _____ Date of Birth: _____ Social Security: _____

Employer Name: _____ Insurance Company: _____

Group Number: _____ Policy Number: _____ Effective Date: _____

Relationship to Subscriber: _____ Phone Number: _____

Insurance Co. Address: _____

EMERGENCY INFORMATION

Emergency Contact Person: _____

Relationship to Patient: _____ Phone Number: _____

Email Address: _____

Please Select Yes or No to the Following Questions:

Have seen a dentist in the last six months? ◯ yes ◯ no

Do you have cavities or gum problems that need treatment or have been treated? ◯ yes ◯ no

If so, please explain:_____

Have you had any injuries to the teeth, jaws, or head? ◯ yes ◯ no

If so, please explain:_____

Do you see a physician? ◯ yes ◯ no

Do you have a medical, psychiatric, physical or other health condition that required past or ongoing medical doctor visits and/or treatment? ◯ yes ◯ no

If so, please explain:_____

Do you have any history of bleeding problems? ◯ yes ◯ no

If so, please explain:_____

Do you take any prescription or over-the-counter medications? ◯ yes ◯ no

If so, please explain:_____

Do you have any allergies to medication, food, or environmental substances? ◯ yes ◯ no

If so, please explain:_____

Are you pregnant or is there a chance you are pregnant? ◯ yes ◯ no

I certify this information is true and correct to the best of my knowledge. I understand that I am responsible for all financial charges.

Name: _____ Date: _____

PRIVACY NOTICE & CONSENT FORM

This notice describes how medical information about you may not be used and disclosed and how you can get access to this information. Please review it carefully.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email/home addresses, social security numbers, and demographic data) may be used or disclosed in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.).
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment etc.).
- To certifying, licensing, and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure, or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patient(s) and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you may have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information

This form is optional under the new patient privacy regulations recently issued by the U.S. Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.
Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email/home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account, or health care operations (i.e., performance reviews, certification, accreditation, and licensure).
You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.
We may amend the above privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.
You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action had been taken in reliance on the consent.

Thank you for your cooperation. Please let us know if you have any questions.

DATE _____

PATIENT OR PARENT/GUARDIAN SIGNATURE _____