Orthodontic Acquaintance – PERSONAL INFORMATION

Date Today: ____________

Patient's Name: ________________________ Preferred Name: ____________ Sex: ____

Home Address: ________________________ Date of Birth: ____________

Home Phone: ____________ Name of Family Physician: ________________________

Whom can we thank for referring you to this office? ________________________

Information for ADULT Patients:

Place of Business: ________________________ Business Phone: ____________

Occupation: ________________________ Marital Status: ____________

Name of Spouse: ________________________ Occupation: ____________

MEDICAL HISTORY

Are you in good health?	☐ Yes	☐ No	Reason: ________________
Any major or unusual illnesses?	☐ Yes	☐ No	Explain: ________________
Currently under physician's care?	☐ Yes	☐ No	Reason: ________________
Currently taking medication?	☐ Yes	☐ No	List: ________________
Allergies	☐ Yes	☐ No	List: ________________
Drug sensitivity	☐ Yes	☐ No	List: ________________

Please check if you have had any of the following:

☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Frequent Colds or Flu
☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Hearing Problems
☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Tonsillitis/Adenitis
☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Endocrine Problems	☐ Yes	☐ No	Tonsils Removed Age: ____
☐ Yes	☐ No	AIDS antibody positive	☐ Yes	☐ No	Bone Disorders	☐ Yes	☐ No	Adenoids Removed Age: ____
☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Asthma
☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Mouthbreathing: ________
						☐ Yes	☐ No	Emotional Problems

Dental History

Name and address of your general dentist: ________________________

When did you last see the dentist: ________________________

☐ Yes	☐ No	Have you had any severe head or face injuries? Explain: ____________
☐ Yes	☐ No	Have you had a history of thumb sucking or finger sucking? Stopped: ____________
☐ Yes	☐ No	Do you play any musical (wind) instruments? What? ____________
☐ Yes	☐ No	Have you consulted an orthodontist previously? ____________
☐ Yes	☐ No	Have you had an previous orthodontic treatment? ____________

Please check if there is a history of:

☐ Clenching Teeth	☐ Headaches (more than normal)	☐ Jaw Joint Popping
☐ Grinding Teeth	☐ Jaw Joint Soreness	☐ Ringing in the Ears
☐ Muscular Soreness around Head & Neck	☐ Jaw Joint Clicking	

Is there any other information that may be helpful? ________________________

Why are you seeking orthodontic consultation? ________________________

Person responsible for payment of account? ________________________

Insurance Company: ________________________

This office will assist you in filing your insurance. Services rendered are charged to the patient, not the insurance company, and patients are expected to take care of their fees as services are rendered.

Thank you

Signed: ________________________ Date: ____________

Insurance Information

This office will assist you in filing your insurance. Services rendered are charged to the patient, not the insurance company, and patients are expected to take care of their fees as services are rendered. *In separation/divorce situation, the individual who initiates services with us is held financially responsible. We do not bill another person or an estranged spouse unless the individual informs us in writing of his or her willingness to pay for services.

I authorize payment directly to the orthodontist of the group insurance benefits otherwise payable to me.

Signature (*Responsible Party):*___________________________________ Date: __________

PLEASE PROVIDE INSURANCE CARD IF AVAILABLE

Primary Insurance Company: ____

Insurance Address: ____

City: ___________________ State: _____ Zip: __________ Phone #: _________________

Patient's Name: ______________________________ Patient's date of birth: ____________

Policy Holder's Name: ______________________________ Date of birth: _____________

Address: _______________________City: ______________ State: _____ Zip: __________

Group number: ____________________ SS#: _____________________________________

Employed by: ______________________________ Phone #: _________________________

Secondary Insurance Company: ____

Insurance Address: ____

City: ___________________ State: _____ Zip: __________ Phone #: _________________

Policy Holder's Name: ______________________________ Date of birth: _____________

Address: _______________________City: ______________ State: _____ Zip: __________

Group number: ____________________ SS#: _____________________________________

Employed by: ______________________________ Phone #: _________________________

-OFFICE USE ONLY-

Lifetime Max: ____________ Yearly Max: ____________ Pays out at: ____________%
Deductible: ____________ Benefit Used: ____________ Benefit Remaining: ____________
Effective Date of Coverage: _________________________ Waiting Period? 0 Yes 0 No
Insurance pays: Monthly _____ Quarterly _____ Automatic _____ Bill mo ____ quart ____

Date: ______________

PREWITT AND PREWITT ORTHODONTICS
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Cell Phone: ______________________ E-Mail: ______________________

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING 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 accompanies 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 issue 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 revisions of our Notice, at any time by contacting:

Contact Person: Kailey Butler
Telephone: (910) 484-7878 Fax: (910) 484-0505
Address: 203 Fairway Drive, Fayetteville, NC 28305

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 heath information to carry out treatment; payment activities and health care operations.

SIGNATURE: ____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Representative's name: ______________________ Relationship to Patient: ______________

Right to Revoke: You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocations 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.

REVOKING OF CONSENT:
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activity, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you receive this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

SIGNATURE: ______________________________ **DATE:** ______________

You are entitled to a copy of this consent after you sign it. Include completed consent in patient's chart.