Orthodontic Acquaintance • PERSONAL INFORMATION

Date Today: _____

Patient's Name: _____ Preferred Name: _____ Sex____

Home Address: _____ City: _____ Zip: _____ Date of Birth: _____

Home Phone: _____ Name of Family Physician: _____

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

Information for MINOR Patients:

School: _____ Grade: _____

Interests: _____

What is the child's attitude toward: Brushing: _____ Dentistry: _____ Orthodontics: _____

	Father	**Mother**
Name:	_____	_____
Address & Phone #	_____	_____
Place of Business:	_____	_____
Business Phone #:	_____	_____
Occupation:	_____	_____

Parents' Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If divorced, who has custody of child? _____

Please check length of time patient will be residing in Fayetteville:

☐ Indefinately ☐ 1 year or less ☐ 6 months or less Explain: _____

MEDICAL HISTORY

Is the patient 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 patient has or has had any of the following:

☐ Anemia	☐ Heart Murmur	☐ Frequent Colds or Flu	☐ Mouth breathing
☐ Blood Disease	☐ Heart Disease	☐ Hearing Problems	☐ Rheumatic Fever
☐ Prolonged Bleeding	☐ Tuberculosis	☐ Tonsilitis/Adenitis	☐ Epilepsy
☐ Hepatitis	☐ Diabetes	☐ Tonsils Removed: Age:___	☐ Emotional Problems
☐ AIDS antibody positive	☐ Endocrine Problems	☐ Adenoids Removed: Age: ___	☐ Herpes
☐ Jaundice	☐ Bone Disorders	☐ Asthma	

Growth information for patients under 16 years of age:

Father's height _____ Mother's height _____ Adopted? ☐ Yes ☐ No

Patient resembles: ☐ Father ☐ Mother ☐ Neither parent

Girls: Has she started menstruation? ☐ Yes ☐ No

Boys: Has his voice changed? ☐ Yes ☐ No

Names and ages of Patient's brothers & sisters: _____

Have any had Orthodontic treatment? ☐ Yes ☐ No When? _____

DENTAL HISTORY

Name of patient's General Dentist: _____

When did patient last see the Dentist? _____ How often does the patient see the Dentist? _____

Has the patient had any severe head or face injuries? ☐ Yes ☐ No Explain: _____

Has the patient had a history of thumb sucking or finger sucking? ☐ Yes ☐ No Stopped? ☐ Yes ☐ No

Does the patient play any musical (wind) instruments? ☐ Yes ☐ No Which? _____

Has the patient consulted an orthodontist previously? ☐ Yes ☐ No Explain: _____

Has the patient had any previous orthodontic treatment? ☐ Yes ☐ No Explain: _____

Please check if you have a history of:

☐ Clenching Teeth	☐ Ringing in the Ears	☐ Jaw Joint Clicking	☐ Headaches (more than normal)
☐ Grinding Teeth	☐ Jaw Joint Soreness	☐ Jaw Joint Popping	☐ Muscular Soreness around head and neck

Is there any other information that may be helpful? _____

Why are you seeking orthodontic consultation? _____

Person responsible for payment of account? _____

This office will assist you in filing your insurance. Services rendered are charged to the patient/parent, not the insurance company, and patients are expected to take care of their fees as services are rendered. In separation/divorce situations, the individual who initiates services with us is held responsible. **WE WILL NOT BILL ANOTHER PERSON OR AN ESTRANGED SPOUSE UNLESS THAT INDIVIDUAL INFORMS IN WRITING OF HIS OR HER WILLINGNESS TO PAY FOR SERVICES.**

Thank you!

Signed _____ Date: _____

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.

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 ____