Patient Information

Today's Date:___________

Patient Name:__________________________Title:_______ Prefers to be called_______________

Date of Birth:____________________ ☐Male ☐Female

Home Address: ____

Home Phone:______________________ Cell:____________________ Work:____________________

Email: _____________________________

Responsible Party (ies)

1. Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other:___________

Name:_______________________________________

Home Address: ____

Home Phone:______________________ Cell:____________________ Work:____________________

Email: _____________________________

2. Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other:___________

Name:_______________________________________

Home Address: ____

Home Phone:______________________ Cell:____________________ Work:____________________

Email: _____________________________

Dental Insurance Information

Policy Holder's Name: ___________________________________ Date of Birth:_________________

Employer: ______________________________________ Employer Phone#:____________________

Employer Address:____

Insurance Co:___________________________________ Ins. Co. Phone#:______________________

Insurance Co. Address: ____

Insurance ID#:__________________________________ Group#:_____________________________

Does this plan have orthodontic benefit? ☐Yes ☐No If yes, how much? $_______________

Phone:______________________ Relation to Patient: _____________________________________

Do you have dual coverage? ☐Yes ☐No

Policy Holder's Name: ___________________________________ Date of Birth:_________________

Employer: ______________________________________ Employer Phone#:____________________

Employer Address:____

Insurance Co:___________________________________ Ins. Co. Phone#:______________________

Insurance Co. Address: ____

Insurance ID#:__________________________________ Group#:_____________________________

Does this plan have orthodontic benefit? ☐Yes ☐No If yes, how much? $_______________

Phone:______________________ Relation to Patient: _____________________________________

I understand that my signature authorizes release of any information relating to my dental insurance claims necessary to pay the claim.

I understand that I am responsible for any balance regardless of my insurance benefits.

I request that payment of authorized benefits be made either to myself or on my behalf to Mid-State Orthodontics.

____ _______________________

Parent/Guardian Signature Date

Medical History

Physician:_______________________________________ Last Visit: __________________

Address:____ Phone#:____________________

☐Yes ☐No Is the patient currently under a physicians care?

Reason: ____

Is there a history of: **Check all that apply**

☐ Heart Disease
☐ Rheumatic fever
☐ Heart Murmur
☐ High Blood Pressure
☐ AIOS/HIV
☐ Frequent Colds
☐ Emotion Problem
☐ Psychiatric Therapy

☐ Kidney Disease
☐ Diabetes
☐ Seizures
☐ Asthma
☐ Arthritis
☐ Birth Defects
☐ Digestive Disorder
☐ Hospitalization/Surgery

☐ Nasal Blockage
☐ Drug/Alcohol/Tobacco Use
☐ Hepatitis/Jaundice
☐ Tuberculosis
☐ Thyroid Disease
☐ Major Illness
☐ Blood Disorder
☐ Unusual Childhood Disease

If you answered yes to any of the above, Please explain: _____________________________

☐Yes ☐No Is the patient currently taking any medication(s)?

List: ____

☐Yes ☐No Does the patient have any food or drug allergies?

List: ____

☐Yes ☐No Is the patient taking or taken in the past medications known as Bisphosphonates? (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa)

Young Female Patients:

☐Yes ☐No Has the patient started monthly menstrual cycles? When:_______________

Dental History

General Dentist:____ Last Visit: ____________________

Address:____ Phone#:_____________________

Why is the patient seeking treatment?____

What should treatment accomplish?____

Is there a history of: **Check all that apply**

☐ Clicking of the Jaw Joints	☐ Tongue Thrusting Habit	☐ Prior Orthodontics
☐ Pain in the Jaw Joints	☐ Grinding Teeth	☐ Extra Teeth
☐ Injuries to the Teeth	☐ Pen/Lip/Nail Biting	☐ Extraction of Teeth
☐ Injuries to the Face	☐ Thumb or Finger Sucking	☐ Missing Teeth
☐ Difficulty Chewing	☐ Chewing Gum	☐ Speech Problem
☐ Fever Blisters/Ulcers	☐ Mouth Breathing	☐ Dry Mouth

Release and Consent

To the best of my knowledge all the preceding answers are true and correct. I hereby give my permission to Mid-State Orthodontics to take the necessary X-Rays, Photos, or Study Models to enable a Complete Diagnosis as well as use of these records for educational purposes.

_____________________________________ _____________________

Signature (Patient /Parent/Guardian) Date

_____________________________________ _____________________

Provider Signature Date

HIPAA OMNIBUS RULE & CONSENT FORM

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM FOR MID-STATE ORTHODONTICS

Patient Name(s):____ Date: ________________

1. CONSENT TO RELEASE INFORMATION TO ESCORTING PARTIES

We request that a Parent/Guardian be present at least every other orthodontic appointment for a comprehensive conversation regarding orthodontic progress and/or questions regarding financial arrangements and/or past due accounts. We recognize, however, that from time to time it may be necessary for someone other than a parent or guardian to accompany the child for treatment. With execution of the Consent to Release Information to Escorting Parties, we are asking you to provide us with written authorization to release your child's or ward's information regarding his or her orthodontic progress, oral hygiene, compliance, or any other necessary information pertaining to the potential success of their orthodontic treatment to a third party.

As the parent and/or guardian of____________________________________ , I hereby give consent to Mid-State Orthodontics to provide information about my child's or ward's orthodontic progress, oral hygiene, compliance, or any other necessary information that pertains to the overall success of their orthodontic treatment to the persons listed below. I also understand, as the responsible party for my child's treatment, that Mid-State Orthodontics is requesting my attendance at least at every other appointment as a way to ensure appropriate personal communication on my child's orthodontic treatment.

This Consent to Release Information to Escorting Parties shall be effective immediately, and shall continue in full force and effect until I withdraw it by written notice provided to Mid-State Orthodontics

Please list below those individuals who may escort your child to their appointments and to whom Mid-State Orthodontics may release the afore described information:

Name:___________________________ Relationship:_______________________

Name:___________________________ Relationship:_______________________

2. Besides those already listed in section 1, **PLEASE LIST ANY OTHER PARTIES WHO ARE AUTHROIZED TO HAVE ACCESS TO YOUR HEALTH INFORMATION:** (This includes stepparents, grandparents, and any caretakers who can have access to this patient's records):

Name:___________________________ Relationship:_______________________

Name:___________________________ Relationship:_______________________

3. I authorize Mid-State Orthodontics to utilize numerous methods for appointment reminders, treatment information, patient health, financial information and special office events. These methods can include cell phone, home phone, email and US mail.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We under current HIPAA omnibus Rule, provide this information with your knowledge and consent.

***The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____________________________ __________________________________

Print Name **Signature**

You may refuse to sign this acknowledgement & authorization. In refusing, we may or be allowed to process your insurance claims.

Office Use Only **

As Privacy Office, I attempt to obtain the patient's (or representatives) signature on this acknowledgement, but did not because:

☐ It was emergency treatment ☐ I could not communicate with the patient

☐ The patient refused to sign ☐ Other:______________________________

Signature of Privacy Officer: ____

RELEASE AUTHORIZING USE OF PERSONAL LIKENESS

I, ______________________________________ consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by Mid-State Orthodontics for the following:

- ☐ advertising to the general public (including social media and electronic media)

- ☐ for educational purposes only (ex. Reviewing cases with patient's dentists)

- ☐ no authorization for use of personal images of likeness

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by Mid-State Orthodontics during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Mid-State Orthodontics. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Mid-State Orthodontics will make all reasonable efforts to safeguard my privacy as required by applicable Law, including the Health Insurance Portability and Accountability Act of 1996(HIPAA). I understand, however, that Mid-State Orthodontics cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Mid-State Orthodontics may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Mid-State Orthodontics may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness.

I have read the foregoing in its entirety and understand its terms.

____
Patient Name

____
Patient/Guardian Signature

____
Guardian name/relationship to patient
(If patient is a minor)

____
Date