DOYLE ORTHODONTICS

PATIENT LAST NAME:_____ FIRST:_____ INITIAL: _____

Nickname/Preferred Name:_____ DOB: _____

Parent or Legal Guardian:_____ Relationship to Child: _____

Address:_____ City:_____ State:_____ Zip:_____.

Telephone (Mobile):_____ Work:_____ Home: _____.

Email:_____@_____ How did you hear about our practice: _____.

INSURANCE INFORMATION (*PLEASE PRESENT YOUR INSURANCE CARD TO BE PHOTOCOPIED FOR OUR RECORDS)*

Primary Insurance	**Secondary Insurance**
Subscriber Name	Subscriber Name
Subscriber ID	Subscriber ID
Date of Birth	Date of Birth
Relationship to Subscriber Self Spouse Child Other	Relationship to Subscriber Self Spouse Child Other
Employer Name	Employer Name
Employer Phone	Employer Phone
Insurance Company	Insurance Company
Insurance Group	Insurance Group
Insurance Phone	Insurance Phone

EMERGENCY CONTACT

Last Name:_____ First:_____ Initial: _____ DOB: _____

Address (if different above)_____ City:_____ State:_____ Zip_____.

Telephone (Home):_____ (Work)_____ (Mobile) _____.

Email:_____@_____ Relationship to Parent:_____.

Authorization

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/ data rates may apply, and I may opt-out of receiving electronic communications at any time. I attest to the accuracy of the information on this page.

*Signature:*_____ *Date:*_____.

Responsible party, if under 18

Medical History

Patient Full Name:_____Nickname: _____Date of Birth____/____/____
Gender: M/ F Race/Ethnicity:_____ Height: _____ Weight:_____ Date of last physical examination_____
Name/address/phone of primary physician: _____
Name/address/phone of medical specialists:_____
Is patient being treated by a physician at this time? □yes □no
Reason:

_____

Is patient taking any medications? Prescriptions, over the counter, vitamins? □yes □no
List name, dose, frequency & date started:_____
Has patient ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?□yes □no
List date & describe:_____
Has patient ever had a reaction to or problem with an anesthetic? □yes □no
Describe_____
Has patient ever had a reaction or allergy to an antibiotic, sedative, or other medications? □yes □no
List_____
Is patient allergic to latex or anything else such as metals, acrylic, or dye? □yes □no
List_____
Is patient up to date on immunizations against childhood diseases? □yes □no

Please mark YES if patient has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of these conditions applies to your child.

Any Problems with growth & birth defects, syndromes or inherited conditions? □yes □no
Heart problems (including congenital heart defects/disease, heart murmur, irregular heart beat or high blood pressure □yes □no
Asthma or breathing problems □yes □no
Bladder and/or kidney problems □yes □no
Jaundice, hepatitis or liver problems □yes □no
Gastroesophageal/acid reflux or stomach problems □yes □no
Developmental disorder, learning problems/delays, autism, cerebral palsy, ADD/ADHD □yes □no
Diabetes, thyroid or other endocrine problems □yes □no
Epilepsy, convulsions/seizures □yes □no
Cancer or other malignancies □yes □no
Behavioral, emotional, communication, or psychiatric problems/treatment □yes □no
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorders □yes □no
Bladder or kidney problems □yes □no
Arthritis, scoliosis, limited use of arms and legs, or muscle/bone/joint problems □yes □no
Rash/hives, eczema or skin problems □yes □no
Abuse (physical, psychological, emotional, or sexual) or neglect □yes □no
Thyroid or pituitary problems □yes □no
Anemia, sickle cell disease/trait, or blood disorder □yes □no
Hemophilia, bruising easily, or excessive bleeding □yes □no
Transfusions or receiving blood products □yes □no
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions □yes □no
Precocious puberty or hormonal problems □yes □no

PROVIDE ADDITIONAL DETAILS HERE:

_____
_____
_____

_____
_____

Is there any other significant medical history pertaining to this patient or his/her family that the dentist should be told?
□*yes* □*no*
Please describe:

_____
_____
_____

Authorization & Release

I have read and answered the above questions to the best of my knowledge.

_____ _____ _____
PATIENT NAME PATIENT OR GUARDIAN SIGNATURE DATE

PATIENT/RELATIVE HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other health care providers involved in my treatment). Obtaining payment from third party payers (ie. my insurance company). The day to day health care operations of your practice I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I,_____, understand that by signing this Consent form, I am giving my consent to Children's Dental & Orthodontics to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name:_____Relationship: