PATIENT INFORMATION

WELCOME TO OUR OFFICE!

Date _____ Gender M F Date of Birth _____ Age _____

Patient's Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *Zip*

Primary Phone # _____ Social Security # _____

How would you like to receive appointment reminders? ☐ Email Email address _____
☐ Text Mobile # _____

Patient's Family Dentist _____

How did you hear about our practice: _____

Names of any relatives treated here _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last *First* *Middle* *Marital Status*

Residence _____
Street *City* *State* *Zip*

Mailing Address _____
Street *City* *State* *Zip*

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street *City* *State* *Zip*

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ Email _____

Spouse's Name _____ Relationship to Patient _____
Last *First* *Middle*

Spouse's Employer _____ Occupation _____ Email _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Subscriber ID # _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue:

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Subscriber ID # _____

Insurance Co. Address _____

Insured's Employer _____

SIGNATURE ON FILE

I hereby consent to the taking of x-rays, photographs and other necessary records (records will not be taken and treatment will not start without a signature.) I understand that requests to copy/transfer records made within 12 months of the initial exam will incur the full records fee of $330. **Initials**: _____

I consent to the examination and treatment of _____. I authorize the release of any and all of the named patient's dental records, including but not limited to: records of office visits and treatment rendered, x-rays, x-ray reports and photographs. Such records may be released to another dentist or orthodontist, or any other health care professional, for the purposes of discussing my condition, consulting on my case, or reviewing my dental records. These records may also be released to any governmental agencies, insurance companies, employees of insurance companies, any managed care organizations which contract with my insurer for the purpose of reimbursement, submitting claims for services rendered or to be rendered to the named patient, or performing quality by law. This authorization shall remain in effect for fifteen years from the below said date. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature, if minor) _____ Date _____

OFFICE USE ONLY

Office: _____

Patient Name _____ Record No. _____

Date of Birth _____/_____/_____

MEDICAL HISTORY

Physician _____
Address _____
Phone No. _____

1. When was your last physical exam? _____
2. Have there been any changes in your general health with the past year? _____
3. Is a physician for any reason treating you at present? _____
4. What medicine(s) are you taking now? _____
5. Have you ever been hospitalized for any illness, accident or surgery? _____
   If yes, when and why? _____
6. Woman: Are you pregnant now? _____

Do you have or have you had any of the following:

	Yes	No		Yes	No
7. Heart Trouble (including heart murmurs, valve, prosthesis/pacemaker)			26. Allergy, hay fever, hives		
8. Rheumatic fever			27. Asthma		
9. High/Low blood pressure			28. Sinus problems		
10. Kidney problems			Are you allergic to or have you had any unusual reactions to the following?		
11. Liver Disease (hepatitis)					
12. Jaundice				Yes	No / Unknown
13. Diabetes			29. Penicillin		
14. Anemia, Sickle cell, Iron			30. Dental local		
15. Prolonged bleeding			31. Barbiturates		
16. Severe infections			32. Codeine or other narcotics		
17. Epilepsy					
18. Fainting			33. Aspirin		
19. Convulsions			34. Sedatives		
20. Pneumonia			35. Sulfa		
21. Tuberculosis			36. Specify other		
22. Venereal Disease, AIDS, ARC			Do you have any other disease, condition		
23. Latex or vinyl (glove) allergy			emotional problems you would like to bring		
24. Metal Allergies (jewelry, etc.)			to our attention?		
25. Arthritis					

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

DENTAL HISTORY

HAVE YOU EVER HAD THE FOLLOWING TREATMENT:	YES	NO
Orthodontic (straightening of the teeth) As a child _____, or an adult _____.		
Extractions How long ago_____ Reason for extractions _____		
Periodontal treatment		
Mouthguard or splint (plastic device between your teeth)		
Treatment or surgery to change your bite		

ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

Sores, lumps or irritated areas in your mouth		
Food catching or collecting between your teeth		
Clenching or grinding your teeth		
Clicking, popping or grating noise in your jaw when chewing Does it bother you? _____		
Numbness or tingling in your mouth or face		
Would you change anything about your teeth or smile?		

Over the past five years, how often have you been seen for teeth cleaning? _____

The date of your last visit to a dentist _____.

That dentist's name _____

DATE: _____ PATIENT SIGNATURE _____

412 North Tioga Street, Ithaca, NY 14850, (607) 272-3921
18 Church Street, Cortland, NY 13045, (607) 753-3371
703 South Decatur Street, Watkins Glen, NY 14891, (607) 535-4929
www.delightfulsmiles.com

AUTHORIZATION TO DISCLOSE

Patient Name: _____ **DOB:** _____

It is the policy of this practice not to release confidential medical information regarding your treatment to family members or friends, except for the following: (1) parent/legal guardian; (2) other persons authorized by the patient; (3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object that that person is entitled to received information regarding your treatment); (4) emergency situations; or (5) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, caretakers/babysitters, or any individual or organization you designate please indicate that below:

I authorize Orthodontic Group of the Finger Lakes (the orthodontist and other providers and employees involved in my care, visits, billing and payment) to disclose my Personal Health Information (PHI) to the following individuals or organizations:

_____

_____

The purpose(s) of which the information will be used or disclosed:

_____

(If purpose is not designated we will infer "at the request of the individual.")

This Authorization shall be in force and in effect until _____ at which time this Authorization to use or disclose this Protected Health Information shall expire. If a date is not provided, this Authorization will remain in place until revoked or changed by the patient or the patient's representative in writing.

I understand that I have the right to revoke or change this Authorization, in writing, at any time by sending such written notification to the practice at its address above. I understand that a revocation is not effect to the extent that the practice has relied on the use or disclosure of the Protected Health Information.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protect by Federal or State law or the HIPAA privacy and security rules.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provided Authorization for the requested use or disclosure.

I understand that this Authorization will enable my health care provide to discuss any or all of my health-related information with the aforementioned individual(s) and/or organizations either over the phone, via email or face-to-face including but not limited to, my HIV status, mental health and drug/alcohol use, and rehabilitation history.

_____

Patient Signature or Signature of Patient's Authorized Representative **Date**

If signed by Patient's Authorized Representative, please print name and describe the representative's authority to act for the patient:

/

_____

Print Name of Patient or Patient's Authorized Representative / Reason for Authority to Sign on Patient's Behalf