BRODERICK DUSEK & DELEON ORTHODONTICS

Date: _____
Patient #: _____
NP Appt.: _____

ADULT PATIENT INFORMATION

Patient's name _____
Last First Middle

Mailing Address _____
Street City Zip

Home phone_____ Work phone_____

Cell Phone_____ Birth date_____ Age____ Social Security #_____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____

Spouse's Name_____

Employer_____ Occupation_____ Work Phone_____

Whom may we thank for referring you to our office? _____

General Dentist_____

Have we treated any other member of your family? Name_____ Relationship_____

Emergency contact: Name_____ Phone_____ Relationship_____

Do you have orthodontic insurance? Yes_____ No____

***As a courtesy to you we accept assignment of insurance benefits from most insurance companies. However, the balance is your responsibility whether your insurance company pays or not. You must make sure we have your current insurance information on file. Your insurance policy is a contract between you and your insurance company. We are not part to that contract.**

Office Notes: _____

Drs. Broderick, Dusek, & DeLeon Orthodontics

500 Eisenhower Drive
Savannah, Georgia 31405

Telephone: (912) 355-7022
Fax: (912) 355-1415

Patient's Name_____ **Date**_____

Medical History

	YES	NO		YES	NO
Diabetes	☐	☐	Blood Disorder	☐	☐
Asthma	☐	☐	Heart Disorder	☐	☐
Seasonal Allergies	☐	☐	Pacemaker or Hearing Aid	☐	☐
Drug Allergies	☐	☐	Are Tonsils Present	☐	☐
Broken Bones	☐	☐	Osteoporosis	☐	☐

If Yes to any questions, please Specify:_____

_____

List any serious or chronic illness:_____

_____

List any Medications being taken:_____

_____

Are you taking any medications for osteoporosis?_____

Dental History

What is the name of your Dentist?_____

When was the last time you saw the Dentist?_____

When were the last X-rays taken?_____

Have there been injuries to the teeth or jaws (falls, blows, chips)?_____

Any habits that might cause an orthodontics problems (thumb sucking, mouth breathing, etc)?

_____

Has an orthodontist been previously consulted?_____ How long ago?_____

How often does the patient brush his or her teeth?_____

Attitude of patient toward orthodontic treatment: Favorable_____ Indifferent_____ Negative_____

Patient's Signature_____ **Date**_____

Parents Signature_____ **Date**_____
(If patient is a minor)

Privacy Consent and Patient Authorization Form

This form is required by the patient privacy regulations issued by the United Stated Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign, and date this form.

Your protected health information (i.e. individually identifiable information such as names, dates, phone numbers, email addresses, and demographic data) as well as photographic and radiographic images may be used in connection with your treatment, payment of your account or health care operations. This signed form will allow us to leave appointment information, financial information or anything that might be pertinent to the patient on your cell phone. You have the right to request restrictions on the use of your protected health information.

Our office is only able to have one party be held responsible for the account. We will be happy to file insurance that is through another party. We must have a completed claim form with the insured's signature and the responsible party's signature allowing us to disclose the information to the insurance company and the insured's signature for authorization of payment.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. We may amend the privacy notice at any time. If we do, we will provide you with a copy of the changes.

_____ _____

Patient Name (PLEASE PRINT) DATE

_____

Patient-Parent-Guardian (PLEASE PRINT)

_____

Patient-Parent-Guardian (SIGNATURE)

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request clinical and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the responsible party's consent. If you wish to have your medical information and/or financial information released to any family members you must list them on this form.

I authorize Drs. Broderick, Dusek and DeLeon Orthodontics to release my records and any information requested to the following individuals.

1._____Relationship to Patient_____

2._____Relationship to Patient_____

3._____ Relationship to Patient_____

4. _____Relationship to Patient_____