BRODERICK DUSEK & DELEON ORTHODONTICS

Date: _____
Patient: _____
NP Appt: _____

CHILD PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Date of Birth: _____ Age: _____ Sex: M____F___
Address: _____City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Is patient a full time student? Yes_____ No_____ Name of School Attending: _____

General Dentist: _____ Primary Physician: _____ Phone: _____
Who may we thank for referring you? _____
Have we treated any other family members? _____ Name _____ Relationship_____
Emergency contact: Name _____Phone:_____ Relationship_____

Fathers Name: Dr.____ Mr.____ _____ Address _____
Home Phone: _____ Cell: _____ Work: _____
Date of Birth: _____ Employer: _____

Mothers Name: Dr.____ Ms.____ Mrs. ____ _____ Address: _____
Home Phone: _____Cell: _____Work: _____
Date of Birth: _____ Employer: _____

Person Financially Responsible for Account (Insurance cannot be the responsible party)

Name: Mr.___ Mrs. ___ Mr. & Mrs. _____ **Fathers SS#**____ _____
Mothers SS#_____

If different from father or mother please fill below
Name: Mr.____Mrs._____Mr. & Mrs._____ Relationship to patient: _____
Date of Birth: _____ **SS#**_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Address: _____ Phone: _____

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 party to that contract.**

Office Notes: _____
_____
_____
_____
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_____
_____
_____

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_____