

**PATIENT INFORMATION**

Date: \_\_\_\_\_  
Last Name \_\_\_\_\_ First \_\_\_\_\_  
Nickname: \_\_\_\_\_ Male Female DOB \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Patient Cell #: \_\_\_\_\_ Patient Home #: \_\_\_\_\_  
Patient Email: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Sports: \_\_\_\_\_ Teams: \_\_\_\_\_  
How did you hear about us? \_\_\_ Upstate Parent Magazine \_\_\_ Internet ad \_\_\_ School \_\_\_ Signage \_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
What is your chief concern that brings you to our office? \_\_\_\_\_  
Patients' current family dentist: \_\_\_\_\_ Last Cleaning: \_\_\_/\_\_\_/\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Marital Status: \_\_\_\_\_ SS # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Previous Address (if less than 3 years) \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Work #: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ # of Yrs Employed: \_\_\_\_\_  
Spouse's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Marital Status: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ # of Yrs Employed: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Primary Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_  
Insured's SS # \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_  
Insurance Co. Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_  
Insured's SS # \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_  
Insurance Co. Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_



ASHBY PARK  
Family Orthodontics

**Medical History**

Patient Name \_\_\_\_\_ D.O.B \_\_\_\_\_  
Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? \_\_\_\_\_  
Yes No Are you allergic to any medication? \_\_\_\_\_  
Yes No Do you have a history of a major illness? \_\_\_\_\_  
Yes No Have you had any operations? \_\_\_\_\_  
Yes No Have you ever been involved in a serious accident? \_\_\_\_\_  
Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

- |                              |                            |                         |
|------------------------------|----------------------------|-------------------------|
| Abnormal bleeding/Hemophilia | Diabetes                   | Pneumonia               |
| Anemia                       | Dizziness                  | Prolonged Bleeding      |
| Arthritis                    | Epilepsy                   | Radiation/Chemotherapy  |
| Asthma or Hay fever          | Gastrointestinal Disorders | HIV/Aids                |
| Rheumatic Fever              | Bone Disorders             | Heart Problems          |
| Kidney problems              | Tuberculosis               | Congenital Heart Defect |
| High Blood Pressure          | Herpes                     | Heart Murmur            |
| Nervous Disorders            | Tumor or Cancer            |                         |
| Hepatitis/Liver problems     |                            |                         |

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

**RELEASE AND WAIVER**

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Authorization**

I agree to diagnostic procedures and orthodontic treatments found necessary and desirable by Dr. Jennifer Garvey, Dr. Jennifer Berwick or Dr. Sairah Awan for the patient named above. I will accept responsibility for this account in full should the insurance be denied.

I authorize the use of this signature on all insurance submissions.

I authorize Ashby Park Family Orthodontics to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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ACKNOWLEDGEMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES

The people listed below may have access to the patient's records and authorize treatment:

_____	_____
Person who may have information	Relationship to Patient
_____	_____
Person who may have information	Relationship to Patient
_____	_____
Person who may have information	Relationship to Patient

Ashby Park has my permission to contact me in the following ways:

Phone Call (confirmation)  
 Leave message on machine  
 Email \_\_\_\_\_

Please provide a current email address for confirmation of appointments

**PLEASE PRINT patient(s) name below:**

Patient(s) Name: \_\_\_\_\_ D.O.B \_\_\_\_\_  
 \_\_\_\_\_ D.O.B \_\_\_\_\_  
 \_\_\_\_\_ D.O.B \_\_\_\_\_

Who has custody of the patients listed above? \_\_\_\_\_

\_\_\_\_\_  
 Signature of Parent/Legal Guardian Date

\_\_\_\_\_  
 Please PRINT name listed above Relationship to Patient(s)