PATIENT HISTORY UPDATE

Name ______________________________________ DOB ___________________ Date _______/_______/__________

The following questions are designed to update your health history, insurance and personal information, and to make us aware of any changes regarding your appointments in our office:

Does the patient have or has the patient had any of the following? (Please check all that apply.)

❍High/Low Blood Pressure ❍Diabetes ❍Asthma/Hay Fever ❍ Jaundice ❍Rheumatic Fever
❍Venereal Disease ❍Epilepsy ❍Aids/HIV ❍Hepatitis ❍Arthritis
❍Fainting Spells/Seizures ❍Radiation Therapy ❍Heart Trouble ❍Stomach Ulcer

❍Yes ❍No Is the patient pregnant? Due date:_________________________________
❍Yes ❍No Does patient require antibiotics prior to treatment? If yes, please describe_______________________________
❍Yes ❍No Has there ever been trauma to patient's face/teeth? If yes, please describe______________________________
❍Yes ❍No Is the patient presently under the care of a physician for an illness or disease?
If yes, please describe ____
❍Yes ❍No Does the patient have a bleeding tendency or do wounds heal slowly?
❍Yes ❍No Is the patient allergic to nickel, latex or any drugs or medications?
If yes, please describe ____
❍Yes ❍No Is the patient taking any medications? If yes, please describe____

❍Yes ❍No Has your dental insurance changed?
If yes, please describe____

Mailing address ____
Primary # _____________________ Work # _______________________ Emergency # ____________________________
Responsible Party Name _____________________________________ Relationship ____________________________________
E-mail address ____

Other than responsible party, who else can bring patient to appointment, discuss financial or schedule appointments?
Name ____ Relationship __________________________
Name ____ Relationship __________________________

To the best of my knowledge, the questions on this update form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform Family Orthodontics of any changes in my medical status. I also authorize Family Orthodontics to perform any necessary orthodontic services that I may need.

_________________________________ _________________
Patient/Responsible Party Signature Date

Patient consent for use and disclosure of protected health information
I have read and received the Notice of Privacy Practices and hereby give my consent for Family Orthodontics to use and disclose health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO).

_________________________________ __________________________________ _________________
Please print name Patient/Responsible Party Signature Date

CHANGE OF INSURANCE FORM

Date ______________

***__This is NOT a guarantee of benefits or payment. Actual benefits can not be determined until actual claim is received by carrier. As per contract patient is responsible for any balance denied or rejected by insurance carrier__ ***

Patient Name: ______________________________ Account Number:___________________________

Patient's Date of Birth: _____________ Location:_______________ Initial Start Date:________________

Policy Holder's Name: ___________________________________ Policy Holder Birth date:____________

Policy Holder's Address ____ Zip Code________________

Employer:____________________________________ Insurance Company:______________________

Effective date of New Insurance: ___________________

Insurance Co. Phone Number:_____________________ Group Number:____________________________

Policy Holder Social Security Number: _________________________

****Copy of Insurance card attached****

INFORMATION AND PAYMENT AUTHORIZATION RELEASE

I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment.

_____________________________ _______________
Signature (responsible party) Date

I hereby authorize payment directly to Family Orthodontics of the group insurance benefits otherwise payable to me.

_____________________________ _______________
Signature (responsible party) Date