



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 Part 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 Specialists in Orthodontics of any changes in my medical status. I also authorize Specialists in 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 Specialists in 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 Specialists in Orthodontics of the group insurance benefits otherwise payable to me.

Signature (responsible party)

Date