Date_____

Patient's Name_____

Address_____

Home/Cell Number_____ Social Security Number_____

Birthday _____/_____/_____ Age_____ Sex Female Male

Email Address_____

Whom may we thank for referring you? _____

Family members with previous orthodontic treatment_____

General Dentist_____

Responsible Party Information

Name _____

Mailing Address_____

Home Number_____ Cell Number_____

Email Address_____

Social Security Number_____ Birthday _____/_____/_____

Employer_____ Work Number_____

Occupation_____ Years Employed_____

Emergency Information

Notify in case of emergency _____

Home Number_____ Cell Number_____Work Number_____

Relationship to Patient_____

Dental History

Date of last check up_____
Why are you interested in orthodontic treatment? _____
Have you been examined by an orthodontist? _____
Have you had any injuries to the face, mouth or teeth? _____

Habits:	Thumb or Finger Sucking……	yes	no
	Mouth Breathing……..	yes	no
	Nail/ Lip Biting……	yes	no
	Grinding or Clenching of Teeth……..	yes	no
	Tongue Thrusting……..	yes	no
Have you been informed of any missing or extra permanent teeth ……		yes	no

Other information about your dental health or any previous treatment_____
Do you have any conditions that require premedication prior to any dental procedures?
_____

Medical History

Physician_____ Phone _____
Date of Last Visit_____ Under care of a Physician Now? Yes No
Describe_____
Adenoids or tonsils been removed? Yes No
Circle if you have had any of the following:

AIDS/HIV Positive	Anemia	Artificial heart valve	Asthma
Cancer	Chemotherapy	Circulatory problems	Diabetes
Epilepsy	Fainting	Headaches	Heart Murmur
Hepatitis	Liver Disease	High Blood Pressure	Herpes
Nervous problems	Pacemaker	Rheumatic/Scarlet Fever	Sinus problems
Shortness of breath	Skin Rash	Surgical Implant	Thyroid Disease
Tobacco Habit	Tonsillitis	Tuberculosis	

Women: Are you pregnant? YES NO Nursing? YES NO
Any allergies or drug sensitivity_____
List any medications you are taking_____

Authorization

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees.

Signature_____ Date_____

PRIMARY ORTHODONTIC INSURANCE INFORMATION

Primary Insured Name_____

Primary Insured Address_____

Primary Insured Phone_____ Birthdate _____/_____/_____

Primary Insured SSN_____ Relationship to Patient_____

Insurance Company_____Employer_____

Insurance Address_____

Insured ID #_____ Group #_____

Do you have orthodontic coverage YES NO Lifetime max _____

SECONDARY ORTHODONTIC INSURANCE INFORMATION

Primary Insured Name_____

Primary Insured Address_____

Primary Insured Phone_____ Birthdate _____/_____/_____

Primary Insured SSN_____ Relationship to Patient_____

Insurance Company_____Employer_____

Insurance Address_____

Insured ID #_____ Group #_____

Do you have orthodontic coverage YES NO Lifetime max _____

AUTHORIZATION INFORMATION

I authorize all insurance benefits otherwise payable to me for services rendered, to be paid to Barra Orthodontics. I authorize the use of this signature on all insurance submissions. I authorize the dentist 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_____

Barra Orthodontics

PATIENT CONSENT FORM

By signing this form, you are granting consent to Barra Orthodontics, to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing the web site at www.barraorthodontics.com. You may also contact us at 717-263-5916.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. This request must be in writing. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature_____ **Date**_____

Relationship to Patient: _____ Self_____ Parent or Legal Guardian

AUTHORIZATION FOR INFROMATION RELEASE

I, _____, the responsible party for _____ give permission for the following person/persons to obtain/inquire about financial and medical information.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name _____ Relationship to Patient_____

Signature_____ Date_____

HIPAA POLICY

I have received Barra Orthodontic's HIPAA Privacy pamphlet.

Signature_____