Rose Orthodontics

PATIENT INFORMATION:

Mr. Mrs. Ms. Miss Dr. Rev. Child

Patient Name: _____
Last First

Age_____ Male/Female Date of Birth _____

Address _____ City/State/Zip _____

Preferred phone number: _____

Who is your general dentist? _____ Physician _____

PARENT/GUARDIAN INFORMATION:

Father: Dr. Mr. Rev. _____ Place of Employment _____

Home Address _____ City/State/Zip _____

Telephone Numbers:

Home _____ Cell _____ Work _____

Mother: Dr. Mrs. Ms. Miss Rev. _____ Place of Employment_____

Home Address _____ City/State/Zip _____

Telephone Numbers:

Home _____ Cell _____ Work _____

**** Names/Ages of Other Family Members We Have Treated:** _____

_____

WHO IS FINANCIALLY RESPONSIBLE: ____ Mother ____ Father ____Both ____ Self

INSURANCE INFORMATION (If Orthodontic Coverage Applies)

Primary Dental Insurance:

Carrier Name _____

Phone No. _____

Subscriber Name _____

Subscriber Employer _____

Subscriber Date of Birth _____

Subscriber SSN / I.D. No. _____

Plan Group No. _____

Secondary Dental Insurance:

Carrier Name _____

Phone No. _____

Subscriber Name _____

Subscriber Employer _____

Subscriber Date of Birth _____

Subscriber SSN / I.D. No. _____

Plan Group No. _____

PATIENT SIGNATURE / PARENT OR GUARDIAN FOR MINOR:

_____ TODAY'S DATE: _____

Rose Orthodontics

Patient Name _____

Last First

	YES	NO
Is the patient in good health?	☐	☐
Is the patient under the care of a physician?	☐	☐
Is the patient presently taking medication?	☐	☐

If so, explain: _____

_____

Does the patient have any history of:

Frequent colds?	☐	☐
Allergies?	☐	☐
Is the patient allergic to any latex or metal?	☐	☐
Is the patient allergic to any medications?	☐	☐
If so, which one (s) _____		
Seasonal allergies?	☐	☐
Heart trouble, diabetes, asthma, T.B., kidney or liver disease, or any other disorder? If so, please explain: _____	☐	☐

_____

Unfavorable reaction to dental care?	☐	☐
Previous orthodontic treatment?	☐	☐
Injury to teeth?	☐	☐
Have tonsils and adenoids been removed?	☐	☐
Is the patient cooperative at home?	☐	☐

Please check any habit (s) of patient:

☐ Thumb/Finger sucking ☐ Nail biting

☐ Mouth breathing ☐ Grinding of teeth

Comments: _____

_____

Today's Date: _____

Rose Orthodontics

PHI Access to Family, Friends, or Others Directly Involved in the Patient's Care Form

You must complete this form if you wish for Rose Orthodontics, when appropriate and necessary, to share protected health information (PHI) whether in person, over the phone, or electronically with any family member, close friend, or other person who is involved in your care.

Patient Name: _____

Date of Birth: _____

Rose Orthodontics is permitted to share protected health information (PHI), including without limitation, appointment information, diagnosis, or treatment plans, with the following individual(s) who is a family member, close friend, or other person involved in the patient's care. Patients signing this form expressly grant permission to Rose Orthodontics to share PHI.

Name:	Relationship (e.g. family member, friend, etc.):
_____	_____
_____	_____
_____	_____

Patient/Parent Signature: _____

Date: _____

I no longer want Rose Orthodontics to share protected health information (PHI) with the following individual(s) who is a family member, close friend, or other person involved in my care and who was permitted to receive my PHI.

Name:	Relationship (e.g. family member, friend, etc.):
_____	_____
_____	_____
_____	_____

Patient/Parent Signature: _____

Date: _____