____

DOB ______________________

PATIENT INFORMATION (CONFIDENTIAL)

Name ____ Home # _____________________ Cell#________________________

Address ____ City ______________ State _______ Zip __________________

Email Address _______________________Would you prefer to have appointments confirmed by? ☐home # ☐cell # ☐text ☐email

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Widowed ☐Separated

If Student, Name of School/College ________________________________ ☐FT ☐PT City ________________ State _______

Patient's or Parent's Employer ____ Work Phone __________________

Business Address ___________________________________ City _______________ State _______ Zip __________________

Spouse or Parent's Name ____________________________ Employer __________________ Work Phone _____________

Whom May We Thank for Referring You? ____

Person to Contact in Case of Emergency ____ Phone __________________

Responsible Party

Name of Person Responsible for this Account _____________________________________ Relationship to Patient __________________

Address ____ Home Phone _____________________

Driver's License # ______________________ DOB ____________________ Financial Institution ____________________

Employer ____ Work Phone __________________ SSN# ____________________

Is this Person Currently a Patient in our office? ☐Yes ☐No

Insurance Information

Name of Insured ____ Relationship to Patient __________________

DOB ____________________ Social Security # ________________________ Date Employed___________________________

Name of Employer ______________________________ Union or Local # _____________ Work Phone __________________

Address of Employer ______________________________ City _________________ State ________ Zip _______________

Insurance Company________________________________ Group #____________________ Policy/ID #____________________

Ins. Co. Address___________________________________ City_________________ State________ Zip_________________

How much is your Deductible? __________ How Much Have Your Used? _________ Max. Annual Benefit? ___________

DO YOU HAVE ANY ADDITION INSURANCE? ☐YES ☐NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured____ Relationship to Patient ___________________________

DOB____________________ Social Security #_________________________ Date Employed__________________________

Name of Employer_____________________________ Union or Local #_________________ Work Phone__________________

Address of Employer______________________________ City__________________ State____________ Zip____________

Insurance Company________________________________ Group #____________________ Policy/ID______________________

Ins. Co. Address___________________________________ City__________________ State____________ Zip____________

How Much is your Deductible?___________ How Much Have You Used?___________ Max. Annual Benefit____________

Over Please

Patient Medical History

Physician________________________ Office Phone________________________ Date of Last Exam______________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain_________________ ________________________________		
3. Are you taking any medication(s) Including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ________________________________ ________________________________ ________________________________		
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐

	Yes	No
8. Are you allergic to or have you had any reactions to the following?	☐	☐
Local Anesthetics (eg. Novocain)	☐	☐ .
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Asprin	☐	☐
Any Metals (e.g. Nickel, Mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)______________________	☐	☐
9. Woman Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking Oral Contraceptives?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other________________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ____ **Date of Last Exam**_________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (Joint, Ear, Side of Face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

X____

Authorization for Release/Use of Protected Health Information in the Form of Photos, Radiographs and Electronic Images.

Name of Office: _______________Crawford Orthodontics______________________

Your photos and x-rays are part of your diagnostic and clinical records and are considered to be protected health information under federal HIPAA Privacy Laws

We make use of radiographs (x-rays), photographs and digital images. These images may be used for diagnosis, documentation, reference, teaching and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, television, on digital media and on our webpage. In some instances, you may be recognized in some of theses images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

___ I authorize the use of my images where my face is identifiable
___ I authorize the use of my images where only my teeth are identifiable
___ I authorize the use of my radiographs

The purpose of this request to release and/or disclose the PHI described above is for personal reasons, I understand that I have the right to revoke this authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer by protected by this rule.

I understand that the health care provider can’t condition treatment on whether I sign this authorization. This authorization will expire at such time that:

____I determine that I no longer wish for my images to be used and I revoke this authorization in writing; or
___ The following date: ____________________________ (within one year of current date).

Signature of patient: ______________________________________ Date: ___/___/___

Personal Health Information Release Form

(HIPAA Release Form)

Name: ____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of any and all information including the diagnosis, financial and dental records; examination rendered to me and claims information. This information may be released to

[ ] Spouse ____

[ ] Children ____

[ ] Other ____

[ ] Information is not to be released to anyone

This **release of Information** will remain in effect until terminating by me in writing.

Messages

Please call my [ ] home [ ] work [ ] cell phone: ____________________________________

If unable to reach me;

[ ] please leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (day) ____________ between (time)____________

I understand that this office will try to accommodate my wishes about my contact information, but have to contact me at the other numbers if unable to contact me at my requested number.

Signed: ____ Date _____/_____/_____

Recall/Next Appt Date:________

New Patient Appt Date: ________

Insurance Information

Email Address to be contacted at: ____

Policy Holder Name: ____

Relationship to Patient: ____

Policy Holder Date of Birth: ____

Policy Holder Address: ____

____

Policy Holder Employer: ____

Policy Holder SSN or Ins ID: ____

Patient Name: ____

Patient Date of Birth: ____

Copy of Insurance Card (Front and Back)

or

Name of Insurance Company: ____

Insurance Payer ID **(Office Use Only)** : ___________________Group ID: _______________________

Insurance Phone Number____

Insurance Address: ____

(Office Use Only) Verification Date: ___________