crawford ORTHODONTICS LLC

ROBERT CRAWFORD, DMD

Orthodontic Acquaintance Sheet DOB_____

Patient's Name_____ Age_____ Sex: Male ☐ Female ☐
First Middle Last

Name Patient Prefers to be called_____ Home Number_____ Cell Number_____

Home Address_____ City_____ State_____ Zip Code_____

Email Address _____ Would you prefer to have appointments confirmed by? ☐home number ☐cell number ☐text ☐email

School_____ Grade_____ Last Visit to Dentist_____

Patient's Dentist_____ Physician_____

Whom may we thank for referring you?_____

Father's Name_____ DOB_____ Occupation_____

Employed by_____ Business Telephone_____

Business Address_____ Soc Sec No_____

Mother's Name_____ DOB_____ Occupation_____

Employed by_____ Business Telephone_____

Business Address_____ Soc Sec No_____

Name of Person Responsible for Account_____

Relationship to Patient_____

Marital Status ☐Married ☐Divorced ☐Separated ☐Single

Names and Ages of Other Children in Family_____

Do you have dental insurance that covers orthodontic treatment? ☐ Yes ☐No

Name of Insurance Company_____

Is orthodontic coverage with mother, father, both, or other?_____

Is the patient under the care of a physician for a specific problem at the present time? ☐Yes ☐No Illness_____

List any medicines your child is currently taking_____

List any drug sensitivities_____

List any serious illness, accidents, or operations_____

PLEASE CIRCLE THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ High Blood Pressure	☐ Allergies or Asthma	☐ Speech Problems
☐ Glaucoma	☐ Head of Facial Injury	☐ Rheumatic Fever	☐ Emotional Problems
☐ Heart Trouble	☐ Tonsillitis	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Hearing Disorder	☐ Bleeding Problems	☐ Nervous Disorders
☐ Hepatitis/Liver Disease	☐ Ear Infections	☐ Epilepsy	☐ Adopted

Has the patient reached puberty?

Girls: Has she started menstruation? ☐Yes ☐No If yes, Month/Year_____

Boys: Has his voice changed? ☐Yes ☐No

Please complete the following information as accurately as possible to help us evaluate family growth pattern:

Father: Height_____ Mother: Height_____ Patient: Height_____ Patient: Weight_____

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? _____ ☐Yes ☐No

Has the patient ever sucked a thumb or fingers? _____ ☐Yes ☐No

Until what age? _____

Has an orthodontist been consulted previously? _____ ☐Yes ☐No

Has the patient had any previous orthodontic treatment? _____ ☐Yes ☐No

If so, by whom? _____

Have you been informed of any missing or extra permanent teeth? _____ ☐Yes ☐No

Has either parent had orthodontic treatment? _____ ☐Yes ☐No

What part of your child's orthodontic problem concerns you the most? _____

List type of band instrument played if any _____

Patient's Hobbies or Interests _____

Additional information which you feel would help make your child's association with us more enjoyable _____

_____

_____

Signature of Parent or Guardian

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: _____