

Patient Name: Dentist:
Patient's Address: Zip: Telephone:
Birthdate: Age: Sex: Cell:
School/Employer: Grade/Position:
Social Security Number: Email:

Primary

Mother Father Step Parent Self Other (specify) Single Married Divorced

Responsible Party: Telephone:
Address: Zip: Cell:
Employer/Address: Telephone:
Social Security Number: Birthdate:

Secondary

Mother Father Step Parent Self Other (specify) Single Married Divorced

Responsible Party: Telephone:
Address: Zip: Cell:
Employer/Address: Telephone:
Social Security Number: Birthdate:

How did you hear about us? (Please check all that apply)

Event: Auction Item: Print Ad: (Where?)
Promotional Item: (circle which) Tooth Token / Water Bottle / T-Shirt Other:
Referral: (circle which) Dr. Wilson or Staff / Dentist / Patient / Other
Name of person we may thank:

Health History Circle Yes or No for which the patient has had a history:

Table with 12 columns: AIDS, Allergies, Anemia, Arthritis, Aspirin, Asthma, Bone Disorders, Bulimia, Cancer, Cerebral Palsy, Chest Pains, Chronic Neck Pain, Clicking of Jaw, Cold Sores / Herpes, Diabetes, Downs Syndrome, Drug Allergies, Emotional Disorders, Epilepsy, Fainting, Dizziness, Glaucoma, Headaches, Heart Condition, Hepatitis, High Blood Pressure, Immune Problems, Kidney Problems, Latex Allergies, Low Blood Pressure, Mouth Breathing, Muscular Disorders, Nervous Disorders, Organ Transplant, Painful Chewing, Periodontal Problems, Pneumonia, Prolonged Bleeding, Rheumatic Fever, Scoliosis, Seizures, Speech Problems, TMJ Problems, Tooth Grinding, Tuberculosis.

Any disease, problems or allergies not mentioned above?:
Current medications?:
Any face, mouth or tooth injuries?:
Is the patient currently pregnant?: How far along?:
Other family members seen by us:
Has the patient had a previous orthodontic exam/consultation?

Insurance Information

Name of Primary Orthodontic Insurance: Telephone:
Name of Policy Holder: Mother Father Step Parent Self Other (specify)
Subscriber's ID Number: Group Number: Date of Birth:
Name of Secondary Orthodontic Insurance: Telephone:
Name of Policy Holder: Mother Father Step Parent Self Other (specify)
Subscriber's ID Number: Group Number: Date of Birth:

I understand that the information provided is correct to the best of my knowledge. This information will be held in the strictest of confidence and it is my responsibility to inform this office of changes to any information or the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services that the patient may need. I understand that I am responsible for the payment of services rendered. I also acknowledge that I have received a copy of the Notice of Privacy Practices.

This office reserves the right to verify, through Orthobanc LLC, the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature: Relationship to Patient: Date:

Please Keep this Page for Your Records

Don L. Wilson, DDS, MSD

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances:

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency or law enforcement agency

For any purposes other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

**Conditions and limitations may apply. Please obtain additional information from the front desk.*

Changes to this notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.

By signing the patient information form, you acknowledge that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.