New Patient Information

Patient Information

Name: ____
First Middle Last

Preferred Name: ______________________________ ☐ *Male* ☐ *Female* ☐ *Prefer not to identify*

Birth Date: ____/____/____ Age: ________ SSN: ________________
MM DD YYYY

Address: ____

____
City State Zip Code

Home Phone: (   ) ____________ Cell Phone: (   ) ____________ Work Phone: (   ) ____________

Email: ____

Satisfaction Regarding Current Smile: ☐ Extremely satisfied ☐ Very ☐ Somewhat ☐ Not very ☐ Not at all satisfied

Whom may we thank for referring you to our office?:

Responsible Party

Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Other*:* ______________________
Check 'Self' if patient is the same as the Responsible Party and skip this section.

Name: ____
First Middle Last

Birth Date: ____/____/____ Age: ________ SSN: ________________
MM DD YYYY

Address: ____

____
City State Zip Code

Home Phone: (   ) ____________ Cell Phone: (   ) ____________ Work Phone: (   ) ____________

Email: ____

Other Members of Household

Name: ______________________ DOB:______ Relationship to Patient:____________
First Last

Name: ______________________ DOB:______ Relationship to Patient:____________
First Last

Name: ______________________ DOB:______ Relationship to Patient:____________
First Last

Name: ______________________ DOB:______ Relationship to Patient:____________
First Last

By providing the phone number(s) above, I expressly consent to receiving telephone calls and/or text messages from the Practice and its agents and representatives via an automatic telephone dialing system, other computer-assisted technology, or pre-recorded message(s), for any purpose, including, but not limited to, appointment and follow-up health care reminders, scheduling, patient account(s), assignment of benefits, and/or financial responsibility. I understand that, depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change.

New Patient Information

Primary Dental Insurance

Subscriber's Name: ______________________________
First MI Last

Subscriber's SSN: ______________________ Subscriber's Birth Date: ___/___/___
MM DD YYYY

Subscriber's Address: ______________________________

____
City State Zip Code

Employer: ______________________________

Insurance ID #: ______________ Employer ID#______________

Insurance Company Name: ______________________ Address: ______________

Insurance Company Phone: ( ) ______________________ Insurance Company Group #: ______________

Secondary Dental Insurance

Subscriber's Name: ______________________________
First MI Last

Subscriber's SSN: ______________________ Subscriber's Birth Date: ___/___/___
MM DD YYYY

Employer: ______________________ Insurance ID #: ______________

Insurance Company Name: ______________________ State: ______________

Insurance Company Phone: ( ) ______________________ Insurance Company Group #: ______________

Primary Dental Practice Information

Practice Name: ______________________ Dentist Name: ______________

Date of Last Cleaning: ______________

Is there pending treatment: ☐ Yes ☐ No

If yes, please explain: ______________________________

____

New Patient Information

Health History Information

Please check all that apply:

☐ Abnormal Bleeding	☐ Allergies to any Drugs	☐ Anorexia/Bulimia
☐ Asthma	☐ Cancer	☐ Congenital Heart Defect
☐ Convulsions/Epilepsy	☐ Diabetes	☐ Finger Sucking
☐ Handicaps/Disabilities Hemophilia	☐ Hearing Impaired	☐ Heart Murmur
☐ Jaw Clicking	☐ Hepatitis A, B or C	☐ HIV Positive/AIDS
☐ Metal Allergies	☐ Kidney/Liver Problems	☐ Latex Allergy
☐ Scarlet Fever	☐ Pregnant	☐ Rheumatic Fever
☒ None	☐ Smoking/Tobacco	☐ Tuberculosis

Please list current medications: ____

____

____

Please list any known drug allergies: ____

____

____

Have you ever taken any medications for osteoporosis? ☐ Yes ☐ No

Please explain any of the above or list any special needs or concerns: ______________________________

____

X-ray Consent

I hereby consent to the making of diagnostic records, including x-rays, before, during, and following orthodontic treatment provided by the doctor(s) and their team (where appropriate) for orthodontic treatment prescribed by the doctor(s) for the below individual. I fully understand all the risks associated with the treatment.

☐ I consent ☐ I do not consent

New Patient Information

Authorization for Release of Patient Information and Use of Records (“Authorization”)

I authorize the release of information in the patient’s record regarding the patient’s treatment, and/or financial obligations related to the patient’s treatment, to the parties listed below. I understand that once personal health and/or financial information is disclosed as per this Authorization, the Practice has no responsibility for any further release by the individual receiving the patient’s information.

I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will neither affect nor limit the patient’s ability to obtain treatment or affect any payment, enrollment, or eligibility for benefits.

I understand that I may revoke this Authorization by sending written notification to the Practice’s Privacy Officer at the address set forth below; provided, however, that my notice to revoke this Authorization will not apply to actions taken in reliance on this Authorization prior to the date my written notice is received by the Practice’s Privacy Officer.

Smile Doctors Orthodontics of Virginia, P.C.
Attn: Privacy Officer
295 SE Inner Loop
Georgetown, TX 78626

This Authorization shall expire upon the earlier of: (i) the termination of the patient’s treatment with the Practice; or (ii) my express written revocation of this Authorization with regard to a recipient. In each case, my historic authorization will remain effective as to protected health information that was disclosed prior to expiration/revocation of this Authorization.

I have read and understand the information contained within this Authorization and selected the applicable responses to indicate my agreement and to allow the use and disclosure of my/the patient’s medical and/or financial record information as described above.

☐ ______________________________ ______________________________
Name of Authorized Person Relationship to Patient

☐ ______________________________ ______________________________
Name of Authorized Person Relationship to Patient

☐ ______________________________ ______________________________
Name of Authorized Person Relationship to Patient

____
Signature of Patient/Responsible Party Date

New Patient Information

Patient / Authorized Representative Authorization for Release of certain Protected Heath Information

By signing this authorization ("Authorization"), I hereby agree as follows:

1. I grant Smile Doctors Orthodontics of Virginia, P.C. ("Practice"), acting through the Practice's employees, agents, contractors, or business associates, the right to use, disclose, and publish certain protected health information ("PHI"), including but not limited to my name, biographical information, voice, photograph, video, and/or likeness, including that which is contained within or related to any patient testimonial, including any such testimonial that I may post on social media or review websites (collectively, the "Information"), for the purposes of marketing, public relations, professional consultations, research, education, or publication in professional journals. Any such Information disclosure made by the Practice may be made available to the general public through the posting of the Information on the Practice's websites, social media pages, and through printed advertisements, television, radio announcements, and other promotional publications of the Practice.

2. I understand that the Practice may use the Information for the purposes outlined in this document and that this may benefit the Practice. I further understand that the Practice does not, and will not ever, owe me any royalty or other amount relating to use of the Information.

3. I understand that I have no right to inspect or approve of any printed or electronic matter that may be used as described herein and that the matter and materials in which my Information is used may be modified, edited, or combined with other materials. I further understand and agree that the Practice will retain the exclusive right to approve or disapprove of the extent, format, and manner in which my Information may be released. I understand and agree that the Practice will not be liable for any publication or broadcast errors.

4. I understand that entering into this Authorization is voluntary, that I may refuse to sign this Authorization, and that the Practice will not condition the commencement or continuation of treatment on my decision as to whether to provide this Authorization, nor would my refusal to sign this Authorization affect any payment, enrollment or eligibility for benefits from any source. I further understand that I may revoke this Authorization at any time after signing it by providing written notice that I would like to revoke this Authorization to the Practice at:

Smile Doctors Orthodontics of Virginia, P.C.
Attention: Privacy Officer
295 SE Inner Loop
Georgetown, TX 78626

5. I understand that my grant of rights to the Practice contained in this Authorization cannot be revoked to the extent that action has already been taken in reliance on this Authorization prior to the date that the Practice receives my written request to revoke this Authorization. This Authorization shall expire ten (10) years from the date of my signature unless I terminate my grant of rights to the Practice contained herein earlier. Such termination of rights shall be on a prospective basis from and after the day on which my revocation is received by the Privacy Officer noted above.

6. I understand that the Practice will not use or disclose my PHI for the reasons set forth herein beyond the scope of this Authorization without my written consent/authorization or as otherwise permitted or required by applicable law. I further understand that disclosed Information may be subject to re-disclosure by the recipient, including any member of the public, and any such re-disclosure shall not require additional consent on my part.

7. I hereby waive, authorize, discharge and agree to hold harmless the Practice and its employees, agents, contractors, or business associates and their respective officers, directors, employees, agents, successors, and assigns and anyone authorized by any of them from any and all losses, damages, costs, expenses, rights, claims, demands, liability and actions, that may result from any use of the Information, including any distortion of my likeness, that may occur in the taking, processing, reproduction, publication or distribution of my Information, including without limitation from any claim for libel, slander, defamation, invasion of right privacy/publicity, false light or any other claim arising from or relating to the exercise of rights granted hereunder.

New Patient Information

8. If this Authorization is signed by the authorized representative of the patient and/or dependent child, the terms “I,” “me,” and “my,” shall be interpreted to apply to the patient, as applicable.

By signing below, I authorize the use or disclosure of the Information, including PHI, as described above, and acknowledge that I have read and accept all of the terms set forth in this Authorization.

All of my questions about this Authorization have been answered in full.

Signature of Patient or Patient’s Authorized Representative ______________________

Print Name ______________________

Relationship (if signed by person other than patient) ______________________

Date ______________________

*   *   *   *   *