PATIENT INFORMATION

Date: _____
Last Name _____ First _____
Nickname: _____ □Male □Female DOB ____/____/____ Age: _____
Patient Cell #: _____ Patient Home #: _____
Patient Email: _____
School: _____ Grade: _____
Sports: _____ Teams:_____
How did you hear about us? ___ Upstate Parent Magazine ___Internet ad ___School ___ Signage ____
Whom may we thank for referring you to our office? _____
What is your chief concern that brings you to our office?_____
Patients' current family dentist: _____Last Cleaning: ____/_____/_____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to patient: _____
Birthdate: ____ /___ /_____ Marital Status: _____ SS # _____
Address: _____City:_____State:_____ Zip:_____
Previous Address (if less than 3 years)_____
Home #: _____ Cell #:_____
Work #: _____ Email: _____
Employer: _____ Occupation:_____ # of Yrs Employed:_____
Spouse's name:_____ Relationship to patient:_____
Birthdate:____ /_____ /_____ Marital Status: _____
Employer:_____ Occupation:_____ # of Yrs Employed:_____

DENTAL INSURANCE INFORMATION

Primary Insured's Name:_____ Birthdate: _____ /_____ /_____
Insured's SS #_____
Name of Employer:_____ Insurance Phone #:_____
Insurance Co. Name and Address:_____
_____

Group #:_____ Policy #:_____

Secondary Insured's Name:_____ Birthdate: _____ /_____ /_____
Insured's SS #_____
Name of Employer:_____ Insurance Phone #:_____
Insurance Co. Name and Address:_____
_____

Group #:_____ Policy #:_____

ASHBY PARK
Family Orthodontics

Medical History

Patient Name_____ D.O.B _____
Physician_____ Date of Last Visit_____
Address_____Phone_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?_____
Yes No Are you allergic to any medication?_____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident?_____
Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia
Anemia
Arthritis
Asthma or Hay fever
Rheumatic Fever
Kidney problems
High Blood Pressure
Nervous Disorders
Hepatitis/Liver problems
Diabetes
Dizziness
Epilepsy
Gastrointestinal Disorders
Bone Disorders
Tuberculosis
Herpes
Tumor or Cancer
Pneumonia
Prolonged Bleeding
Radiation/Chemotherapy
HIV/Aids
Heart Problems
Congenital Heart Defect
Heart Murmur

Are there any medical conditions we have not discussed that you feel we should be aware of?_____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company

SIGNATURE: _____ DATE: _____

Authorization

I agree to diagnostic procedures and orthodontic treatments found necessary and desirable by Dr. Jennifer Garvey, Dr. Jennifer Berwick or Dr. Sairah Awan for the patient named above. I will accept responsibility for this account in full should the insurance be denied.

I authorize the use of this signature on all insurance submissions.

I authorize Ashby Park Family Orthodontics to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE: _____ DATE: _____

ASHBY PARK
Family Orthodontics

ACKNOWLEDGEMENT OF RECEPT
OF NOTICE OF PRIVACY PRACTICES

The people listed below may have access to the patient's records and authorize treatment:

_____ _____
Person who may have information Relationship to Patient

_____ _____
Person who may have information Relationship to Patient

_____ _____
Person who may have information Relationship to Patient

Ashby Park has my permission to contact me in the following ways:

___ Phone Call (confirmation)
___ Leave message on machine
___ Email _____
Please provide a current email address for confirmation of appointments

PLEASE PRINT patient(s) name below:

Patient(s) Name: _____ D.O.B _____
_____ D.O.B _____
_____ D.O.B _____

Who has custody of the patients listed above? _____

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Please PRINT name listed above Relationship to Patient(s)

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