Specialist in Orthodontics and Dentofacial Orthopedics

PATIENT INFORMATION

Date ________________ Patient's Date of Birth ____

Patient's name ______________________________________Nickname____

Address ____
Street City Zip

Home Phone _______________Cell _________________ Work _________________Email__________________________

Mom's Cell______________________ Dad's Cell ______________________Email___________________________________

If patient is a minor, give parent's or guardian's name____

Who does the patient live with? ____

List any medications now being taken and the reason ____

List any allergies or drug sensitivities ____

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

Abnormal Bleeding	Diabetes	Herpes	Pneumonia
ADD/ADHD	Endocrine Disorder	High Blood Pressure	Psychological Issues
Anemia	Epilepsy/Seizures	HIV/AIDS	Radiation/Chemotherapy
Arthritis	Fainting or Dizziness	Immune Disorders	Rheumatic Fever
Asthma	Gastrointestinal Disorders	Kidney Disease	Speech Problems
Bone Disorders/Osteoporosis	Heart Disease	Liver Disease	Snoring
Congenital Heart Defect	Heart Murmur	Mouth Breathing	Tuberculosis
Developmental Delays	Hepatitis	Nervous Disorders	Tumor or Cancer

Are there any other medical conditions that you feel we should be aware of? ______________________________________
____

Name of Family doctor or specialists____

DENTAL HISTORY

Name of General Dentist ____ Date of last visit ____________________________

Has there been any trauma to the teeth, jaw, or face? ____

Is there any tooth clenching or grinding? Yes No____

Are there any other dental, head, or neck conditions that you feel we should be aware of? _________________________
____

DENTAL INSURANCE INFORMATION

Insured's Name____ Insured's Social Security # ____________________

Insurance Company___________________________ ID#.________________ DOB.___________________________________

Insurance Co. Address____ Phone No. ____________________

EMERGENCY CONTACT INFORMATION

Name of nearest relative or friend not living with you ______________________________Phone_______________________

Complete address ____
Street City Zip

Signature of Patient or Parent/Guardian ____

Specialist in Orthodontics and Dentofacial Orthopedics

IMAGING CONSENT

I hereby consent to Peninsula Orthodontics, P.C. performing radiologic services as ordered and recommended by my dentist or other health care professional.

The risks for submitting to x-rays, including CBCT (Cone Beam Computerized Tomography), have been fully explained to me by my dentist or other health care professional. I have discussed the need for these radiologic services and agree to undergo these service as recommended. I understand that Peninsula Orthodontics P.C. has made no recommendations regarding the need for these services or the type of images to be performed.

I understand that Peninsula Orthodontics P.C. will provide no professional interpretation of the images obtained. I further understand that Peninsula Orthodontics P.C. will provide no treatment and will make no recommendations for treatment based on these radiologic studies to either me, my dentist or other referring party.

If I would like to have my images interpreted by a ***professional dental radiologist*** the cost for such services is $35.

I would like my images interpreted by a dental radiologist Yes________________ No ________________

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses and demographic data) may be used in connection with your treatment, payment on your account or to certifying licensing and accrediting bodies. You have the right to review our office's Privacy Notice prior to signing this Consent Form. A copy will be available upon request. You have the right to request restrictions on the use of your protected health information; however we are not required to honor your request.

We may amend the attached Privacy Notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice. You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

CONSENT TO UNDERGO DIAGNOSTIC RECORDS

I hereby consent to the making of diagnostic records, including x-rays. I fully understand all of the risks associated with the treatment.

*Printed Name of Patient*____

________________________________ *Date*______________ ________________________ *Date* ________
Signature of Patient/Parent/Guardian *Witness*

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize Peninsula Orthodontics to provide other health care providers with information regarding the above individual's care as deemed appropriate. I understand that once released, the doctor and staff have no responsibility for any further release by the individual receiving this information.

CONSENT TO USE OF RECORDS

I hereby give my permission for the use of records, including photographs, made in the process of examinations and treatment for purposes of professional consultation, research, education, or publication in professional journals.

________________________________ *Date*______________ ________________________ *Date* ________
Signature of Patient/Parent/Guardian *Witness*

401 Oyster Point Road, Suite D, Newport News, VA 23602
Phone: 757-249-4203 ✦ Fax: 757-249-4208
www.peninsulabraces.com ✦ info@peninsulabraces.com

PRIVACY CONSENT

This form is required by the new patient privacy regulations issued by the United States Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign, and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses and demographic data) may be used in connection with your treatment, payment on your account or to certifying licensing and accrediting bodies.

You have the right to review our office's Privacy Notice prior to signing this Consent Form. A copy is available on request.

You have the right to request restrictions on the use of your protected health information, however we are not required to honor your request.

We may amend the attached Privacy Notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Thank you for your cooperation. Please let us know if you have any questions.

____
Patient or Parent/Guardian Signature

____
Print Patient's Name

____
Date