PATIENT HISTORY UPDATE

Name _____ DOB _____ Date _____/_____/_____

The following questions are designed to update your health history, insurance and personal information, and to make us aware of any changes regarding your appointments in our office:

Does the patient have or has the patient had any of the following? (Please check all that apply.)

❍High/Low Blood Pressure	❍Diabetes	❍Asthma/Hay Fever	❍ Jaundice	❍Rheumatic Fever
❍Venereal Disease	❍Epilepsy	❍Aids/HIV	❍Hepatitis	❍Arthritis
❍Fainting Spells/Seizures	❍Radiation Therapy	❍Heart Trouble	❍Stomach Ulcer	

❍Yes ❍No Is the patient pregnant? Due date:_____

❍Yes ❍No Does patient require antibiotics prior to treatment? If yes, please describe_____

❍Yes ❍No Has there ever been trauma to patient's face/teeth? If yes, please describe_____

❍Yes ❍No Is the patient presently under the care of a physician for an illness or disease?

If yes, please describe _____

❍Yes ❍No Does the patient have a bleeding tendency or do wounds heal slowly?

❍Yes ❍No Is the patient allergic to nickel, latex or any drugs or medications?

If yes, please describe _____

❍Yes ❍No Is the patient taking any medications? If yes, please describe_____

❍Yes ❍No Has your dental insurance changed?

If yes, please describe_____

Mailing address _____

Primary # _____ Work # _____ Emergency # _____

Responsible Part Name _____ Relationship _____

E-mail address _____

Other than responsible party, who else can bring patient to appointment, discuss financial or schedule appointments?

Name _____ Relationship _____

Name _____ Relationship _____

To the best of my knowledge, the questions on this update form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform Family Orthodontics of South Carolina of any changes in my medical status. I also authorize Family Orthodontics of South Carolina to perform any necessary orthodontic services that I may need.

_____ _____

Patient/Responsible Party Signature Date

Patient consent for use and disclosure of protected health information

I have read and received the Notice of Privacy Practices and hereby give my consent for Family Orthodontics of South Carolina to use and disclose health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO).

_____ _____ _____

Please print name Patient/Responsible Party Signature Date

CHANGE OF INSURANCE FORM

Date _____

***This is NOT a guarantee of benefits or payment. Actual benefits can not be determined until actual claim is received by carrier. As per contract patient is responsible for any balance denied or rejected by insurance carrier ***

Patient Name: _____ Account Number:_____

Patient's Date of Birth: _____ Location:_____ Initial Start Date:_____

Policy Holder's Name: _____ Policy Holder Birth date:_____

Policy Holder's Address _____ Zip Code_____

Employer:_____ Insurance Company:_____

Effective date of New Insurance: _____

Insurance Co. Phone Number:_____ Group Number:_____

Policy Holder Social Security Number: _____

****Copy of Insurance card attached****

INFORMATION AND PAYMENT AUTHORIZATION RELEASE

I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment.

_____ _____
Signature (responsible party) Date

I hereby authorize payment directly to Family Orthodontics of South Carolina of the group insurance benefits otherwise payable to me.

_____ _____
Signature (responsible party) Date