PATIENT INFORMATION

Patient Name: _____ Prefers to be called: _____

Date of Birth: _____ Male: ____ Female: ____ Non-binary: ____

Home Address: _____

Home Phone: _____ Cell: _____

Email address: _____

BILLING PARTY

Relationship to Patient: Self: _____ Spouse: _____ Parent: _____ Other: _____

Name: _____

Home address (if different from above): _____

Home phone: _____ Cell: _____

Email address: _____

DENTAL INSURANCE

Policy Holder's Name: _____ Date of Birth: _____

Employer: _____Employer Phone Number: _____

Employer's address: _____

Insurance Co: _____Ins Co Phone #: _____

Ins Co Address: _____

Insurance ID #: _____ Group #: _____

Does this plan have an orthodontic benefit: Yes____ No ____ Amount: _____

I understand that my signature authorizes release of any information relating to my dental insurance claims necessary to pay the claims. I understand that I am responsible for any balance regardless of insurance benefits. I request that payment of authorized benefits be made either to myself or on my behalf to McClain Orthodontics.

Parent/Guardian Signature: _____ Date: _____

MEDICAL HISTORY

Physician: _____ Last Visit: _____

Address: _____ Phone #: _____

Is there a history of any of the following (**check all that apply**):

___Heart Disease ___Kidney Disease ___Nasal Blockage ___Rheumatic Fever ___Diabetes

___Drug/Alcohol/Tobacco use ___Heart Murmur ___Seizures ___Hepatitis/Jaundice ___High Blood Pressure

___Asthma ___Tuberculosis ___AIDS/HIV ___Arthritis ___Thyroid Disease ___Frequent Colds ___Birth Defects

___Major Illness ___Emotional Problem ___Digestive Disorder ___Blood Disorder ___Psychiatric Therapy

___Hospitalization/Surgery ___Unusual childhood disease

List any medication Patient is currently taking: _____
Does the Patient have any food/drug allergies: _____
Is the Patient taking, or taken in the past, medications known as Bisphosphonates? (Fosomax, Boniva, Skelid, Didronel, Aredia, Zometa): _____
Young female patients: Has the Patient started monthly menstrual cycles?_____When: _____

DENTAL HISTORY

General Dentist: _____ Last Visit: _____

Address:_____ Phone #: _____

Why is the Patient seeking orthodontic treatment:_____ _ Is there a history of (**check all that apply**):

__Clicking of the jaw joints __Tongue thrusting habit __Prior Orthodontics __Pain in the jaw joints __Grinding teeth __Extra teeth __Injuries to the teeth __Pen/Lip/Nail biting __Extraction of teeth __Injuries to the face

__Thumb or finger sucking __Missing teeth __Difficulty chewing __Chewing gum __Speech problem __Fever blisters/ulcers __Mouth breathing __Dry mouth

RELEASE AND CONSENT

To the best of my knowledge, all the preceding answers are true and correct. I hereby give my permission to McClain Orthodontics to take the necessary x-rays, photos, and/or study models to enable a complete diagnosis.

Resp. party signature: _____ Date: _____
Provider's signature: _____ Date: _____

RELEASE OF PERSONAL LIKENESS

I, _____, consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by McClain Orthodontics for the following:

____ Advertising to the general public, including social media and electronic media

____ Education purposes only, including patient education, treatment planning with patient's general dentist

____ No authorization for use of personal images or likeness

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by McClain Orthodontics during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by McClain Orthodontics. I understand and agree that I have no right to be consulted about or approve of any such adjustments before my image is used.

I understand that McClain Orthodontics will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that McClain Orthodontics cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that McClain Orthodontics may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any images of me.

I understand that McClain Orthodontics may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image/likeness.

I have read and agree to the above in its entirety and understand its terms.

Patient Name: _____ Resp. Party signature: _____

Relationship to patient: _____ Date: _____

HIPPA OMNIBUS RULE AND CONSENT

Patient Name: _____ Date: _____

CONSENT TO RELEASE INFORMATION TO ESCORTING PARTIES

As the parent and/or guardian of _____, I hereby give my consent to McClain Orthodontics to provide information about my child's/ward's orthodontic progress, oral hygiene, compliance, or any other necessary information that pertains to the overall success of their orthodontic treatment to the persons listed below. I also understand as the responsibility party for my child's/ward's treatment, that McClain Orthodontics is requesting my attendance to every other appointment to ensure proper communication about my child's treatment.

This Consent to Release information to escorting parties shall be effective immediately and shall continue until I withdraw it by written notice provided to McClain Orthodontics.

Please list below those individuals who may escort your child to their appointments and to whom McClain Orthodontics may release the afore mentioned information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Besides those listed above, PLEASE LIST ANY OTHER PARTIES WHO ARE AUTHORIZED TO HAVE ACCESS TO YOUR HEALTH INFORMATION

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Name: _____ Signature: _____

Office use only

As privacy Officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgement, but did not because:

____It was an emergency treatment ____I could not communicate with the patient

____The patient refused to sign ____Other _____

Signature of Privacy Office: _____