WELCOME!

Please take a few minutes to answer the following questions so we can better assist you with your orthodontic needs.

Patient Information

Date_____ Birth date_____
Name_____
Address_____ Phone_____
City_____ State_____ Zip_____
Sex: ___ M ____F ____Minor ____Married ___Divorced ___Widowed__
Appointment reminders:
Email: _____ Text Message#_____
Employer_____ Business Phone_____
Business Address_____ Occupation_____
Who should we thank for referring you? _____
In case of emergency, who should we contact_____ Phone_____

Person Responsible for Account/ Primary Insurance

Person Responsible for Account_____
Relationship to patient_____ Birth date_____
Address_____ Home Phone _____
City_____ State _____ Zip_____
Employed by_____ Business Phone_____
Business Address_____Occupation_____
Dental Insurance Company_____
Insurance Company Address_____
Subscriber I.D. # _____Group #_____

Secondary Insurance/ Medical Insurance

Insured Name_____
Relationship to Patient_____ Birth date _____
Address_____ Home Phone_____
City_____ State_____ Zip_____
Employed By_____ Business Phone_____
Insurance Company_____
Insurance Company Address_____
Subscriber I.D. #_____ Group#_____

Dental History

Name of Dentist_____
Address_____ Phone_____
Last Dental Visit_____
Has any one in family worn braces? _____

Medical History

Physician's Name_____ Phone _____

Does your medical history include any of these?

1. Is your general health good?	Yes	No
2. Is the patient taking any medication for any reason?	Yes	No
3. Does patient need to be premedicated for dental work?	Yes	No
4. Have you ever had an unusual reaction to any drug?	Yes	No
5. Have you had your tonsils and/or adenoids removed?	Yes	No
6. Have you ever had heart trouble, rheumatic fever or diabetes?	Yes	No
7. Have you ever had infectious hepatitis?	Yes	No
8. Have you had upper respiratory infections?	Yes	No
9. Do you have any allergies? _____	Yes	No
10. Endocrine problems?	Yes	No
11. Anemia?	Yes	No
12. Have you ever had trouble with bleeding after surgery?	Yes	No
13. Are you under a physician's care now?	Yes	No
14. Have you ever tested positive for HIV?	Yes	No
15. Is there any other health information we should know?	Yes	No
16. Have we seen any other family members?	Yes	No

List any drugs or medication you are currently taking_____

Assignment and Release

I hereby authorize payment directly to Central DuPage Orthodontics, Ltd. For all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any providers or supplier of service in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ Date_____

CENTRAL DUPAGE
ORTHODONTICS, LTD.
Beautiful Smiles For Children & Adults
LAURENCE A. GOLDEN, DDS, MSD

Member
American
Association of
Orthodontists
My Life. My Smile. My Orthodontist.

Clinical Assistant Professor
Department of Orthodontics
College of Dentistry
University of Illinois at Chicago

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Initial here _____ - Persons we can share information with in regards to your treatments are: _____

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Central DuPage Orthodontics, Ltd. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Central DuPage Orthodontics, Ltd. at any time at the below address to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Office use only

I attempted to obtain the patients signature in acknowledgment on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: _____ Employee Initial:_____ Reason:_____