BOYD ORTHODONTICS
Creating Your Most Beautiful Smile

## ADULT PATIENT INFORMATION

Today's Date _____

Last Name _____ First Name _____ MI _____ ☐ Male ☐ Female

Date of Birth _____ Age _____ Patient's Preferred Name _____

Address _____ City _____ State _____ Zip _____

Patient Cell #* _____ Home # _____

Patient Email* _____

***Please list primary cell & email to receive appointment reminders via text & email***

Who may we thank for referring you to our office? _____

Family members previously treated here: _____

Please list any other family members you would like us to evaluate: _____

Preferred office location for appointments: ☐ Devine ☐ Spring Valley

## RESPONSIBLE PARTY INFORMATION

Responsible Party's Name _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Relationship to Patient _____ Are you the responsible party for this account? ☐ Yes ☐ No

Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Home # _____ Email _____

Employer _____ Job Title _____ Work # _____

Years of Employment _____

Responsible Party's Name _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Relationship to Patient _____ Are you the responsible party for this account? ☐ Yes ☐ No

Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Home # _____ Email _____

Employer _____ Job Title _____ Work # _____

Years of Employment _____

## INSURANCE INFORMATION

**Do you have orthodontic coverage?** ☐ **Yes** ☐ **No**

**Primary Insurance Company** _____ Insurance Phone # _____

Subscriber Name _____ Employer/Group _____

Subscriber ID#/SSN _____ Subscriber DOB _____ Relationship to Patient _____

**Secondary Insurance Company** _____ Insurance Phone # _____

Subscriber Name _____ Employer/Group _____

Subscriber ID#/SSN _____ Subscriber DOB _____ Relationship to Patient _____

## MEDICAL/DENTAL HISTORY

General Dentist's Name _____ Date of Last Visit _____

Has the patient ever been evaluated or had orthodontic treatment before? ☐Yes ☐No _____

Have there been any injuries to the mouth, teeth or chin? ☐Yes ☐No

Has the patient been informed of any missing or extra permanent teeth? ☐Yes ☐No

Physician's Name _____ Date of Last Visit _____

Is the patient currently being treated by a physician for a specific reason? ☐Yes ☐No

If yes, please list reason _____

Is the patient adopted? ☐Yes ☐No

Please list all medications patient is currently taking: _____

Please list any allergies or sensitivities (drugs, food, etc): _____

Are you currently taking a bisphosphonate for osteoporosis? ☐Yes ☐No ☐Fosamax ☐Boniva ☐Actonel ☐Other

Please check all of the following that apply:

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Jaw Joint Pain | ☐ Teeth Grinding | ☐ Latex Allergy |
| ☐ Epilepsy | ☐ Bone Disorders | ☐ Heart Condition | ☐ Other |
| ☐ Hepatitis | ☐ ADD/ADHD | ☐ Kidney Problems | |
| ☐ HPV Vaccine | ☐ AIDS/HIV | ☐ Endocrine Problems | |

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

**I authorize Richard E. Boyd, DMD, MS, PA to contact me regarding treatment, appointments, financials, insurance, and other communications as indicated below in the checked boxes. I authorize contact from this office via:**

☐ ***U.S. Mail*** ☐ ***Email*** ☐ ***Phone and/or text***

**I authorize this office to disclose and discuss the patient's protected health information to carry out treatment, payment activities, and health care operations with the following individuals:**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

**I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that by signing this consent, I authorize Richard E. Boyd, DMD, MS, PA to use and disclose my protected health information carry out treatment, payment activities, and health care operations. You may obtain a copy of our notice from our office staff or through our website at www.drrichardboyd.com.**

**I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.**

_____ _____

**Signature of Patient** **Date**