Timothy F. Denison, DMD, MSD

Denison Orthodontics

_____ _____

Print Name of Insured/Patient Date of Birth

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, holders of prescription information on me, including but not limited to, pharmacies, pharmacy benefits managers, and insurers, medical facility, or other healthcare professional that has provided payment, treatment of services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, insurance coverage information and any other protected health information concerning me to Denison Orthodontics. This includes information on the diagnosis of treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility, or other healthcare provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Denison Orthodontics may administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage, and conduct other legally permissible activities that relate to any coverage I have or have applied for with Denison Orthodontics.

This authorization shall remain in force for 12 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of "My Providers" have already relied on this Authorization to disclose information about me or to the extent that Denison Orthodontics has a legal right to contest a claim under and insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be re-disclosed by Denison Orthodontics except as authorized by me or as required by law.

I understand that "My Providers" may not refuse to provide treatment or payment for healthcare services if I refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Denison Orthodontics may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____

Signature of Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Timothy F. Denison, DMD, MSD
Orthodontics for Children, Adolescents & Adults

PATIENT'S NAME _____ NICKNAME _____ SEX _____
FIRST MIDDLE LAST

ADDRESS _____ BIRTHDATE: _____/_____/_____
STREET

_____ HOME PHONE _____
CITY STATE ZIP

- FAMILY INFORMATION -

FATHER/SELF _____
NAME ADDRESS IF DIFFERENT FROM ABOVE

S.S.# _____-_____-_____ OCCUPATION _____

EMPLOYER _____ WORK PHONE _____

MOTHER/SPOUSE _____
NAME ADDRESS IF DIFFERENT FROM ABOVE

S.S.# _____-_____-_____ OCCUPATION _____

EMPLOYER _____ WORK PHONE _____

SINGLE MARRIED SEPARATED DIVORCED

PERSON RESPONSIBLE FOR ACCOUNT _____

NAMES & AGES OF OTHER CHILDREN IN FAMILY _____

NEAREST RELATIVE/CLOSE FRIEND TO CONTACT IN CASE OF EMERGENCY (OTHER THAN ABOVE)

NAME AND RELATION _____ PHONE _____

FRIENDS/RELATIVES TREATED HERE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

ARE YOU AWARE THAT PATIENT COOPERATION IS THE MAIN DETERMINATION OF THE LENGTH OF TREATMENT AND QUALITY OF THE RESULTS? YES NO

PATIENT'S ABILITY TO ACCEPT RESPONSIBILITY GOOD AVERAGE POOR

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT POSITIVE NEUTRAL NEGATIVE

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY ? YES NO REMARKS _____

DOES THE PATIENT NOW HAVE OR HAD ANY ORAL HABITS ? (THUMB OR FINGER SUCKING, NAIL BITING...) YES NO

HAS ANY FAMILY MEMBER HAD ORTHODONTIC TREATMENT ? YES NO

REASON FOR CONSULTATION _____

- DENTAL INSURANCE INFORMATION -

EMPLOYEES NAME _____ BIRTHDATE _____/_____/_____

EMPLOYEE ID/S.S.# _____ GROUP/PLAN # _____

EMPLOYER NAME _____

ADDRESS _____
STREET CITY STATE ZIP

INSURANCE COMPANY NAME _____

ADDRESS _____

PHONE NO. ( ) _____

INSURANCE *WILL NOT* BE PROCESSED WITHOUT THE COMPLETE ADDRESS AND PHONE NUMBER FOR THE INSURANCE COMPANY.

- DENTAL INFORMATION -

DENTIST'S NAME_____

DATE OF LAST DENTAL TREATMENT_____ FOR_____

HOW OFTEN DO YOU BRUSH YOUR TEETH_____

DO YOUR GUMS BLEED SOMETIMES?	YES	NO
HAVE YOU EVER NOTICED PURPLISH COLOR ON YOUR GUMS OR CHEEKS?	YES	NO
HAVE YOU EVER HAD PERIODONTAL OR GUM DISEASE?	YES	NO
DO YOU EVER CLENCH OR GRIND YOUR TEETH?	YES	NO
DO YOU FREQUENTLY HAVE HEADACHES, TIRED OR SORE JAW MUSCLES?	YES	NO
HAVE YOU EXPERIENCED JAW JOINT PROBLEMS (PAIN, CLICKING, ETC.)?	YES	NO
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, JAW OR TEETH?	YES	NO

- MEDICAL INFORMATION -

PATIENT'S PHYSICIAN & ADDRESS_____

HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST 2 YEARS? YES NO

LIST ANY MEDICATION YOU TAKE REGULARLY_____

_____

HAVE YOU EVER HAD ANY ABNORMAL REACTION TO DRUGS? YES NO

PLEASE SPECIFY_____

DO YOU HAVE ANY ALLERGIES OR DRUG SENSITIVITY? YES NO

PLEASE SPECIFY_____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES NO WHAT AGE?_____

DOES PATIENT HAVE TENDENCY TO ☐ COLDS ☐ SORE THROATS ☐ EAR INFECTIONS

HAVE YOU EVER HAD CANKER OR COLD SORES ON YOUR LIPS, TONGUE, GUMS OR BODY? YES NO

CIRCLE ANY O F THE FOLLOWING WHICH YOU HAVE HAD OR NOW HAVE:

AIDS	COUGH	HEPATITIS	NERVOUS DISORDER
ALLERGIES	DIABETES	HAY FEVER	PROLONGED BLEEDING
ANEMIA	EPILEPSY	HIGH BLOOD PRESSURE	PNEUMONIA
ARTHRITIS	ENDOCRINE PROBLEMS	HERPES	RHEUMATIC FEVER
ASTHMA	FAINTING OR DIZZINESS	HIV	SINUS TROUBLES
BONE DISORDER	GLAUCOMA	KIDNEY DISEASE	STROKE
CONVULSIONS	HEART PROBLEMS	LIVER DISEASE	TUBERCULOSIS

OTHER_____

- CHILDREN & ADOLESCENTS ONLY -

HAS THE PATIENT REACHED PUBERTY?	YES	NO
GIRLS - HAS STARTED MENSTRUATION?	YES	NO
BOYS - HAS VOICE CHANGED?	YES	NO
DOES THE PATIENT HAVE ANY SPEECH PROBLEMS?	YES	NO

PATIENT'S HEIGHT_____ PATIENT'S WEIGHT_____

FATHER'S HEIGHT_____ MOTHER'S HEIGHT_____

PATIENT'S INTERESTS AND HOBBIES_____

_____

DATE_____ PATIENT SIGNATURE_____

PARENT IF MINOR