# Smith & Smith Orthodontics

**creating beautiful smiles**

## Patient Information


Serving Sanford and Central North Carolina

Phone: 919-774-4744

Fax: 919-776-3531

1800 Doctors Drive  Sanford, NC 27330

sanfordbraces.com


DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Members American Association of Orthodontists

## We will file your insurance for you.

As a courtesy to our patients, we will file your insurance for you so that you may more easily utilize your insurance benefits.

Important: Please notify us as soon as possible about any changes in insurance policy or coverage. To file your insurance successfully, we must have the correct insurance information on file.

Name of Dental Insurance Company:_____

Policy Holder's Name:_____

Policy Holder's Mailing Address:_____

City:_____State_____Zip_____

Policy Holder's Social Security No.:_____Policy Holder's Date of Birth:_____

Name of Employer:_____

Relationship to Patient:_____Patient Name:_____

**AUTHORIZATION:**

*I hereby authorize Brian D. Smith, DDS, MS, PA to release any medical/dental information related to my insurance claim and/or treatment.*

Signed:_____Date:_____

*I hereby authorize payment directly to Brian D. Smith, DDS, MS, PA of insurance benefits otherwise payable to me. I understand that I will be responsible for any portion of the orthodontic fee that my insurance does not cover.*

Signed:_____Date:_____

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## Rewarding patients for a job well done!

**PHOTOGRAPHY RELEASE**

We like to recognize our patients and reward them for winning in-office contests, achievements in school, athletics, community activities, as well as the work they do maintaining their braces by keeping them clean and intact. During the course of treatment, we may want to post a photograph in the office or on our Facebook page. We do this to engage our patients and reward them for a job well done. I hereby give my permission for my child's photograph to be posted in the office of Dr. Brian Smith and Dr. Lynn Smith, and/or for my child's photograph to be posted electronically on the Facebook page and/or website of Dr. Brian Smith and Dr. Lynn Smith.

Patient's Name:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____

Date:_____

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# Authorization for release of information.

Name of Patient _____ Date of Birth _____

Smith and Smith Orthodontics is authorized to release protected health information about the above named patient in the following manner and to persons listed.

| List each person/entity that you approve to receive information. | Check the type of information that the person/entity (listed on left) may receive. |
|---|---|
| Voice Mail | ❑ Results of lab tests/x-rays<br>Other: |
| Spouse (name and phone number) | ❑ Financial<br>❑ Medical |
| Parent (name and phone number) | ❑ Financial<br>❑ Medical |
| Email address* | ❑ Financial<br>❑ Medical<br>❑ Appointment reminders<br>❑ Breach notification |
| * I understand that non-encrypted email communication could be accessed inappropriately. I still elect to allow email communications. | |

**PATIENT RIGHTS:**
I have the right to revoke this authorization at any time. I may inspect or copy the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____
Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____ _____ _____

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# Medical and Dental History - Adult Patients

**PATIENT**

Date_____

Patient Last Name_____First Name_____Middle Name_____

Title (please circle) Mr Mrs Ms Miss Dr

Birth Date_____Sex (M/F)_____

Marital Status (please circle) Married Single Separated Divorced Widowed

Home Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Carrier_____

Occupation_____Employer_____Work Phone_____

Email address_____

**CLOSEST RELATIVE**

Spouse/closest relative's name(s)_____

Title (please circle) Mr Mrs Ms Miss Dr

Address (if different) _____City_____State_____Zip_____

Home Phone (if different)_____Cell Phone_____Work Phone_____

**PATIENT'S DENTIST**

Patient's Dentist_____Address_____

Date Last Seen_____Reason for appointment_____Next Appointment_____

Did your dentist refer you directly to this office? Yes/No

**PATIENT'S PHYSICIAN**

Patient's Physician_____Address_____

Date Last Seen_____Reason for appointment_____Next Appointment_____

Other physicians/health care providers being seen now:

Name_____Address_____

Reason_____

**FINANCIAL RESPONSIBILITY**

Who is financially responsible for this account?_____

Address (City, State, Zip)_____

Home Phone_____Work Phone_____Cell Phone_____

Employer_____Social Security Number_____

## MEDICAL HISTORY

Please circle all that apply. Now, or in the past, has the patient had:

| | | | | |
|---|---|---|---|---|
| Asthma | Cancer | Bone Fractures | Diabetes | Kidney Problems |
| Mental Health Disturbances | Arthritis/Joint Problems | Blood Pressure Problems | Bleeding Problems | Speech Problems |
| Injuries to Face/Head Neck | Eating Disorder | Osteoporosis | Mitral Valve Prolapse | Immune System Problems |
| Birth Defects/ Hereditary Problems | Seizures/Neurological Problems | Endocrine or Thyroid Problems | Heart Defects/Desease or Heart Murmur | Frequent Headaches or Migraines |

Please circle all that apply. Now, or in the past, has the patient had allergies or reactions to any of the following:

Local Anesthetics (Novacaine) Penicillin Metals (Jewelry) Latex Products Other

Please list all medications the patient is currently taking_____

Now, or in the past, has the patient taken medication to treat osteoporosis (bisphosphonates)? Yes/No

If yes, when and for how long?_____

Is the patient currently under the care of a physician? Yes/No If Yes, for what?_____

## DENTAL HISTORY

Please circle all that apply. Now, or in the past, has the patient had:

| | | |
|---|---|---|
| Any Untreated Cavities | Gum Disease | Injury to Permanent Teeth |
| Any Broken/Missing Fillings | Permanent Teeth Removed | Supernumerary (extra) Teeth |
| Impacted Teeth | Congenitally Missing Teeth | Mouth Breathing or Snoring at Night |
| Chipped or Injured Permanent Teeth | Thumb or Finger Habit | Sensitive or Sore Teeth |
| Jaw Fractures, Cysts or Infections | Tooth Grinding or Clenching | TMJ Problems |
| Soreness in Facial or Jaw Muscles | Popping/Clicking of Jaw Joint | Difficulty Chewing |

What is your chief orthodontic concern?_____

How did you hear about our office?_____

Have you ever had previous orthodontic treatment? If so, where?_____

Have you ever had a previous orthodontic exam? If so, where?_____

## RELEASE AND WAVIER

*I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.*

Signature_____Date_____

*I have read the above questions and understand them. I will not hold my orthodontist or any member of this staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.*

Signature_____Date_____

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