

# Parisi Orthodontics

charting the course to exceptional smiles

## Adult Patient Registration

Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_

By what name would you like us to call you? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Has anyone in your family been treated in this office? \_\_\_\_\_

Person responsible for this account: \_\_\_\_\_

### Your Employer

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Business Phone: \_\_\_\_\_

### Spouse

Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Business Phone: \_\_\_\_\_

## **Orthodontic Insurance**

Ins. Co. Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Ins Co. address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

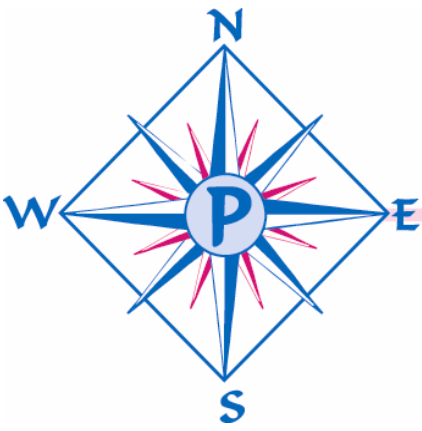
Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID # \_\_\_\_\_ SSN \_\_\_\_\_

Is there any additional insurance that you would like us to check? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## Medical History

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician: \_\_\_\_\_

Date of last physical: \_\_\_\_\_

Have there been any changes in your general health in the last year? Yes / No

If yes, what? \_\_\_\_\_

Are you currently being treated by a physician for any reason? \_\_\_\_\_

If yes, what? \_\_\_\_\_ By whom? \_\_\_\_\_

Have you ever been hospitalized for any illness, accident or surgery? \_\_\_\_\_

If yes, when and why? \_\_\_\_\_

Have you had *tonsils and/or adenoids* removed? \_\_\_\_\_

Are you allergic to any drug or other substances? \_\_\_\_\_

If so, what? \_\_\_\_\_

Females: Are you, or could you possibly be pregnant? \_\_\_\_\_

### *Please circle all conditions that apply*

Heart murmur

Hives/Rash

Hay Fever/Allergies

Heart surgery

TMJ Problems

Epilepsy

Rheumatic/Scarlet Fever

Frequent Headaches

Fainting

Heart Pacemaker

Depression

Aids/HIV

Artificial Heart Valve

Thyroid disorder

Emotional Problems

Artificial Joints

Sinus Trouble

Anxiety

High/Low Blood Pressure

Asthma

Diabetes

Shortness of Breath

Tuberculosis

STD

Implants of Any Kind

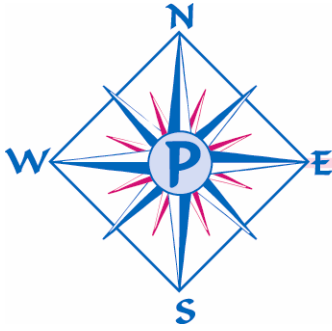
Bronchitis

ADD/ADHD

Is there any condition/problem or other information that you think would be helpful for us to know? \_\_\_\_\_

Signature: patient/parent/guardian

Today's Date



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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### Section A: Patient, Parent or Guardian – Giving Consent

Name (patient, parent or guardian): \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Patient/Parent Social Security #: \_\_\_\_\_

### Section B: To the Patient - Please Read the Following Statements Carefully

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Jennifer Morocko Phone #: (610) 286-1606  
Address: 201 Darby Square, Elverson, Pa. 19520 Fax#: (610) 286-1609

I, (please print) \_\_\_\_\_ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**SIGNATURE:** \_\_\_\_\_ / **DATE:** \_\_\_\_\_  
(circle one): parent/patient/guardian

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

Include completed Consent in the patient's chart.  
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**PLEASE READ AND SIGN THE BACK OF THIS PAPER**