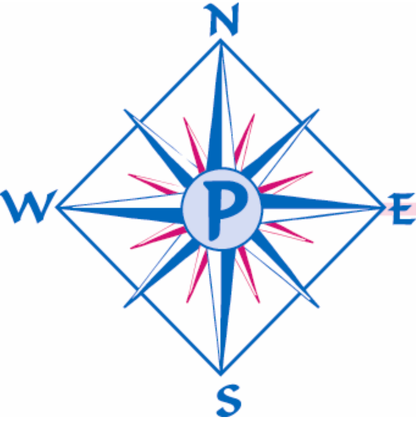


Parisi Orthodontics

charting the course to exceptional smiles

Child Patient Registration

Date: ________________________

Patient's Full Name: _______________________________ Nickname: ________________________
Address: _______________________________City: _________________ State: ____ Zip: _________
Phone: _________________________________ Email Address: _______________________________
Date of Birth: __/__/____ School: _______________________________ Grade: _________
Whom may we thank for referring you to our office? ________________________________
Has anyone in your family been treated in this office? _____________________________
Siblings: list brothers/sisters with age: ____

Father

Name: ___________________________________
Address: ________________________________
Employer: _______________________________
Empl. Address: __________________________
Home Phone: _____________________________
Business Phone: __________________________
Cell Phone: ______________________________
Email Address: ___________________________

Mother

Name: ___________________________________
Address: ________________________________
Employer: _______________________________
Empl. Address: __________________________
Home Phone: _____________________________
Business Phone: __________________________
Cell Phone: ______________________________
Email Address: ___________________________

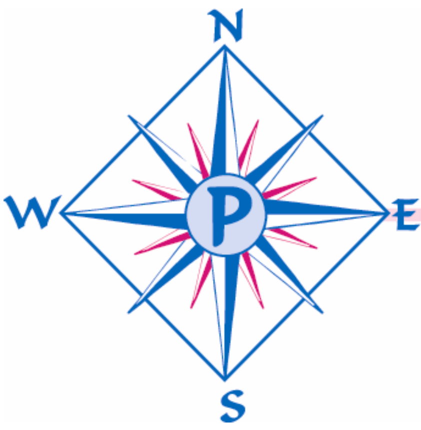
Person responsible for this account: ____
Person responsible for making appointments: ____

Orthodontic Insurance

Ins. Co. Name: __________________________
Ins. Co address__________________________
Subscriber Name: ________________________
Date of Birth: ___________________________

Phone # _________________________________
ID# _____________________________________
SSN: ____________________________________
Group # _________________________________

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



Parisi Orthodontics

charting the course to exceptional smiles

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

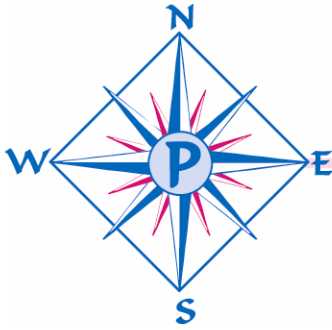
Is there any condition/problem or other information that you think would be helpful for us to know? ____

____

____ _______________________________

Signature: patient/parent/guardian Today's Date

Parisi Orthodontics ~ 201 Darby Square, Elverson, Pa. 19520 ~ (610) 286-1606 ~ www.parisiortho.com



Parisi Orthodontics

charting the course to exceptional smiles

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: 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.
2002 American Dental Association (All rights reserved)

PLEASE READ AND SIGN THE BACK OF THIS PAPER