SNYDER Orthodontics

Dr. Edward P. Snyder, P.C.

BOARD CERTIFIED SPECIALIST IN ORTHODONTICS

PATIENT INFORMATION

Date _____ Email _____ Dentist Name _____

Patient's Name _____ Nickname _____
(FIRST) (MIDDLE) (LAST)

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Birthdate ____/____/____ Age _____ Sex _____

Social Security Number ____-____-____ School _____ Grade _____

RESPONSIBLE PARTY INFORMATION

Father's Name (or Self) _____
Social Security Number ____-____-____
Address (if not same as patient) _____
_____
(CITY) (STATE) (ZIP)
Home Phone _____ Cell Phone _____
Birthdate ____/____/____ Cell Phone Provider _____
Employer _____
Occupation _____
No. Years Employed _____
Employer Address _____
Work Phone _____ Email _____
Best number and time to call _____
(PHONE #) (TIME)

Mother's Name (or Spouse) _____
Social Security Number ____-____-____
Address (If not same as patient) _____
_____
(CITY) (STATE) (ZIP)
Home Phone _____ Cell Phone _____
Birthdate ____/____/____ Cell Phone Provider _____
Employer _____
Occupation _____
No. Years Employed _____
Employer Address _____
Work Phone _____ Email _____
Best number and time to call _____
(PHONE #) (TIME)

Do you have other children in your family? _____ Ages: _____, _____, _____, _____

Person financially responsible for this account: _____

Responsible Party Marital Status: single ❒ married ❒ divorced ❒ widowed ❒

INSURANCE INFORMATION

Do you have orthodontic insurance coverage? ❒ Yes ❒ No Benefit Estimate $ _____

The below information must be completed, signed, and a copy of your insurance card provided before any insurance can be filed.

Insured's Name _____ Birthdate ____/____/____ Social Security Number ____-____-____

Insurance Company _____ Group No. _____ Plan No. _____

Insurance Co. Address _____ Phone _____

2nd Insured's Name _____ Birthdate ____/____/____ Social Security Number ____-____-____

Insurance Company _____ Group No. _____ Plan No. _____

Insurance Co. Address _____ Phone _____

I authorize release of information to all my insurance companies. I understand I AM RESPONSIBLE FOR ANY BALANCE that my insurance does not pay FOR ANY REASON. I authorize payment directly to Dr. Snyder.

SIGNATURE _____ **DATE** _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

This office reserves the right to verify the credit status of potential patients seeking payment terms.

SIGNATURE _____ **DATE** _____

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MEDICAL AND DENTAL HISTORY

GENERAL INFORMATION

What is the reason for seeking Orthodontic advice? _____

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

Has patient or any family member had previous orthodontic care? _____ If so, Name: _____ When? _____

Treated by whom? _____ Address: _____ For how long? _____

(City) (State)

MEDICAL HISTORY

Name and address of patient's physician: _____

Patient's present health is: EXCELLENT GOOD FAIR POOR (Please circle one)

Is the patient under the care of a physician at this time? ❒ Yes ❒ No If so, for what? _____

Is the patient taking any medications now? ❒ Yes ❒ No If so, please list: _____

Is the patient allergic to any medications? ❒ Yes ❒ No If so, please list: _____

Has the patient been diagnosed with arthritis or **osteoporosis**? ❒ Yes ❒ No If Yes, list: _____

If so, is patient taking any medication for this? ❒ Yes ❒ No _____

Does the patient use nicotine containing products/smoke ❒ Yes ❒ No What type? ❒ Smoke ❒ Dip ❒ Chew ❒ Other _____

Does the patient now have or ever had any of the following?

	YES	NO		YES	NO
Rheumatic Fever	❒	❒	Bruise Easily	❒	❒
Heart Murmur	❒	❒	Bladder/Kidney Problems	❒	❒
High/Low Blood Pressure	❒	❒	Jaundice	❒	❒
Anemia	❒	❒	Hemophilia/Abnormal Bleeding	❒	❒
Hepatitis	❒	❒	Speech Problems	❒	❒
Diabetes	❒	❒	Fainting	❒	❒
Liver Disease	❒	❒	Convulsions	❒	❒
Thyroid Problems	❒	❒	Epilepsy	❒	❒
Emotional Problems	❒	❒	Persistent Cough	❒	❒
Asthma/Hay Fever	❒	❒	Frequent Colds	❒	❒
Tonsils/Adenoids Removed	❒	❒	Intellectual and Developmental Disabilities	❒	❒
Fever Blisters	❒	❒	Frequent Headaches	❒	❒
Tumors	❒	❒	Pregnant	❒	❒
HIV+/AIDS	❒	❒	Cancer/Chemotherapy	❒	❒
Heart Attack/Stroke	❒	❒	Heart Surgery/Pacemaker	❒	❒
Mitral Valve Prolapse	❒	❒	Artificial Bones/Joints	❒	❒
Artificial Valves	❒	❒	Drug/Alcohol Abuse	❒	❒
Venereal Disease	❒	❒	Ulcers/Colitis	❒	❒
Congenital Heart Defect	❒	❒	Difficulty Breathing	❒	❒

Has the patient ever been hospitalized? ❒ Yes ❒ No If so, give reason why, length of time hospitalized, and patient's age at the time:

_____

Does the patient have any other disease, condition, or problem not listed above that the doctor should know about?

❒ Yes ❒ No If so, please explain: _____

DENTAL HISTORY

Name of patient's general dentist: _____

Circle if patient has ever had a habit of: SUCKING FINGERS / THUMB / TONGUE / LIP / PACIFIER / OR BITING FINGERNAILS

How severe? _____ How long? _____ When? (nights only, etc.) _____

Has the patient ever experienced a problem with cold sores, canker sores, bleeding gums, or any condition related to their mouth?

❒ Yes ❒ No If so, please explain: _____

Has the patient ever experienced a traumatic event to the mouth, teeth or jaws? ❒ Yes ❒ No If so, please explain:

_____

Signature _____ **Reviewed by:** _____ **Date:** _____

SNYDER Orthodontics

invisalign PROVIDER

HIPPA Form

PRIVACY CONSENT

FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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

Dr. Edward P. Snyder, P.C. at (276) 632-4144.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. 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.

SIGNATURE

I _____ 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:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name_____ Relationship to Patient:_____