

**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

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

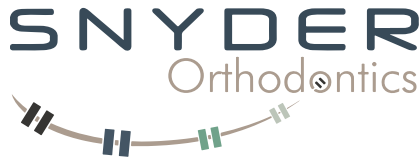
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## 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 \_\_\_\_\_



## 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 . . . . .          | <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily . . . . .                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> | Bladder/Kidney Problems . . . . .                     | <input type="checkbox"/> | <input type="checkbox"/> |
| High/Low Blood Pressure . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia . . . . .                   | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia/Abnormal Bleeding . . . . .                | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis . . . . .                | <input type="checkbox"/> | <input type="checkbox"/> | Speech Problems . . . . .                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes . . . . .                 | <input type="checkbox"/> | <input type="checkbox"/> | Fainting . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease . . . . .            | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions . . . . .                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problems . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional Problems . . . . .       | <input type="checkbox"/> | <input type="checkbox"/> | Persistent Cough . . . . .                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/Hay Fever . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Colds . . . . .                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Tonsils/Adenoids Removed . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | Intellectual and Developmental Disabilities . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever Blisters . . . . .           | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches . . . . .                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumors . . . . .                   | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant . . . . .                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV+/AIDS . . . . .                | <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Chemotherapy . . . . .                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Stroke . . . . .      | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery/Pacemaker . . . . .                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse . . . . .    | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Bones/Joints . . . . .                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Valves . . . . .        | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Abuse . . . . .                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal Disease . . . . .         | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers/Colitis . . . . .                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Defect . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing . . . . .                        | <input type="checkbox"/> | <input type="checkbox"/> |

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

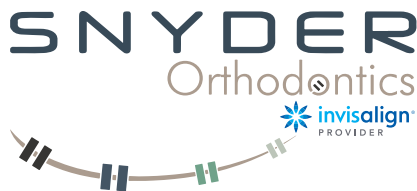
How severe? \_\_\_\_\_ How long? \_\_\_\_\_ When? (nights only, etc.) \_\_\_\_\_

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: \_\_\_\_\_



## 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: \_\_\_\_\_