NEW PATIENT INFORMATION

PATIENT Date: _____

Name _____ ☐ Male

Address _____ ☐ Female

City _____ State _____ Zip _____

S.S. # _____ Date of Birth _____ ( ) _____ ( ) _____

Home Telephone Work Telephone

Email address _____

Referred by _____ Name of Dentist _____ Last visit _____

Other Family (Siblings) Name Age Name Age

_____ _____

_____ _____

RESPONSIBLE PARTY

1- Name _____

Address _____

City _____ State _____ Zip _____

S.S. # _____ Date of Birth _____ ( ) _____ ( ) _____

Home Telephone Work Telephone

Employer's Name _____

Address _____

Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian

2- Name _____

Address _____

City _____ State _____ Zip _____

S.S. # _____ Date of Birth _____ ( ) _____ ( ) _____

Home Telephone Work Telephone

Employer's Name _____

Address _____

Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian

INSURANCE COVERAGE

It is important that you understand that dental and accident insurance policies are an arrangement between the insurance carrier and you. Any amount authorized to be paid directly to the orthodontist will be credited to your account on receipt, and any over payments will be refunded to the appropriate party.

However, you must clearly understand and agree that all services rendered you are charged directly to you and you are personally responsible for payment. Payment for services rendered are due at the time of appointment unless prior arrangements are made with the business office.

In order to facilitate the correct and rapid processing for your insurance claim, we need to have a completed insurance form on file. Please advise us of any insurance changes when applicable.

I hereby authorize payment directly to Bryan L. Garner, D.D.S., M.S. any group dental payments from my insurance company otherwise payable to me, but not to exceed the charges shown. I understand I am financially responsible to said orthodontist for charges not covered by this assignment.

SIGNED (Responsible Party) _____

DENTAL INSURANCE

1- _____

Name of carrier and plan Address Phone #

_____

Name of insured

2- _____

Name of carrier and plan Address Phone #

_____

Name of insured

IT IS YOUR RESPONSIBILITY TO NOTIFY OUR OFFICE OF ANY INSURANCE CHANGES WHEN APPLICABLE.

PATIENT MEDICAL/DENTAL HISTORY

Name: _____
Date: _____

PLEASE MARK THE ITEM/ITEMS YOU HAVE A HISTORY OF:

- ☐ High blood pressure
- ☐ Drug/alcohol abuse
- ☐ Learning disabilities
- ☐ Venereal disease
- ☐ Excessive bleeding
- ☐ Blood transfusion
- ☐ AIDS
- ☐ Psychotherapy
- ☐ Anemia
- ☐ Lupis
- ☐ TB
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Convulsions
- ☐ Heart murmur
- ☐ Chronic cough
- ☐ Mononucleosis
- ☐ Thyroid condition
- ☐ Arthritis
- ☐ Smoking
- ☐ Smokeless Tobacco
- ☐ Fainting
- ☐ Hypoglycemia
- ☐ Hepatitis
- ☐ Hearing Loss

PLEASE MARK ALL THAT APPLY AND PROVIDE EXPLANATION:

☐ Allergies to drugs/medications
_____
_____

☐ Surgery
_____
_____

☐ Under care of dentist, physician, chiropractor
_____
_____

☐ Car accident
_____
_____

☐ Head, neck or face injury
_____
_____

☐ Frequent headaches
_____
_____

☐ Does jaw pop, click or lock
_____
_____

☐ Pain in face, jaw or back
_____
_____

☐ Grind or clench teeth
_____
_____

☐ Medical problems requiring premedication for dental work
_____
_____

LIST ANY AND ALL DRUGS YOU ARE TAKING:
(INCLUDE NAME & REASON FOR USE)

_____
_____
_____

I certify that the above information is correct.

SIGNATURE: _____ DATE: _____

Printed name: _____ Relationship to patient: _____

SIGNATURE OF DOCTOR: _____ DATE: _____

Garner & Associates
Orthodontic Specialists
803 W Elliot Road
Chandler, AZ 85225

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ 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 Policies 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.

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

Chandler Office: **803 W. Elliot Rd**
Chandler, AZ 85225
(480) 963-1355

Queen Creek Office: **23706 S. Power Rd. A-102**
Queen Creek, AZ 85142
(480) 248-1525

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the offices 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 heath 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: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____