KAY ORTHODONTICS

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FOR OFFICE USE ONLY
Date _____
Office: BH / S
ID#_____

PATIENT INFORMATION

Title_____ Legal Name_____
First Middle Last
Nickname_____Birthdate_____ Male ☐ Female ☐

Address_____

City_____State_____Zip_____

Home Phone _____ Cell Phone _____ Last 4 digits of SS#_____

Employer of Patient_____ Work Phone _____

Dentist Name_____ Dentist Phone _____

Dentist Address_____City_____State_____Zip_____

Emergency Contact Person_____ Phone _____

Family members seen by our office_____

Who referred you to our office?_____

FAMILY CONTACT INFORMATION

#1 Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Miss ☐

Full Legal Name_____
First Last
Relationship to Patient ◯ Mother ◯ Father ◯ Step-mother ◯ Step-father ◯ Guardian ◯ Spouse ◯ Other

Address_____City_____State___Zip_____

Home Phone _____Cell Phone _____Last 4 digits of SS#_____

Employer_____ Work Phone _____Ext_____

#2 Mr. ◯ Mrs. ◯ Ms. ◯ Dr. ◯ Rev. ◯ Miss ◯

Full Legal Name_____
First Last
Relationship to Patient ◯ Mother ◯ Father ◯ Step-mother ◯ Step-father ◯ Guardian ◯ Spouse ◯ Other

Address_____City_____State___Zip_____

Home Phone _____Cell Phone _____Last 4 digits of SS#_____

Employer_____ Work Phone _____Ext_____

#3 Mr. ◯ Mrs. ◯ Ms. ◯ Dr. ◯ Rev. ◯ Miss ◯

Full Legal Name_____
First Last
Relationship to Patient ◯ Mother ◯ Father ◯ Step-mother ◯ Step-father ◯ Guardian ◯ Spouse ◯ Other

Address_____City_____State___Zip_____

Home Phone _____Cell Phone _____Last 4 digits of SS#_____

Employer_____ Work Phone _____Ext_____

PLEASE COMPLETE PAGE 2→

Family Name_____ **Date**_____

Please list any other family members (that we have already seen as patients) that we can update:

1) _____ **2)** _____ **3)** _____ **4)** _____

RELEASE OF INFORMATION

I give the office of Kay + McCullum Orthodontics permission to release and/or discuss patient treatment information to the following (must be 18 years or older):

1. **Name**_____ Relationship to Patient_____
2. **Name**_____ Relationship to Patient_____
3. **Name**_____ Relationship to Patient_____
4. **Name**_____ Relationship to Patient_____

Treatment information may include: insurance information, billing information, medical history, treatment history, and/or diagnosis and treatment planning.

TEXT / EMAIL CONTACT INFO

We have the ability to remind you of appointments, send you statements and other correspondence via text messaging and/or email. Please fill out the information below in order for us to communicate with you more efficiently. Please provide only one cell phone number and email address per recipient.

Name _____ Relationship to Patient_____

Cell Phone # _____ AT&T ◯, Sprint ◯, Verizon ◯, T-Mobile ◯, Other ◯

Email Address _____

Name _____ Relationship to Patient_____

Cell Phone # _____ AT&T ◯, Sprint ◯, Verizon ◯, T-Mobile ◯, Other ◯

Email Address _____

Name _____ Relationship to Patient_____

Cell Phone # _____ AT&T ◯, Sprint ◯, Verizon ◯, T-Mobile ◯, Other ◯

Email Address _____

☐ I decline email correspondence. By checking this box, I am indicating that I prefer correspondence to be mailed, and I acknowledge that Kay Orthodontics does NOT mail statements. Paper statements are provided by request during appointments.

I verify that I am legally responsible for the above patient(s) and take responsibility that the contacts given above have my permission to view the specified information from Kay Orthodontics. Furthermore, I am aware that the phone service providers named might charge the recipient for text messages.

HIPAA ACKNOWLEDGEMENT

I have been offered a copy of this orthodontic practice's privacy, security and breach notification policies and procedures. I understand that I should ask the practice's Privacy Official if I have any questions about these policies and procedures.

I verify that I am legally responsible for the above patient and have completed this form as accurately as possible.

Parent Signature _____ Date _____

Relationship to Patient _____

Patient Signature _____ Date _____

(if over 18 years old)