Patient Information:

Patient Name: ______ ______ ___ ______
Last First MI Preferred Name

Gender: ◯ Female ◯ Male **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ **SS#:** ______ **Emergency Contact:** ______ ______
Name Phone

Phone: ______ ______ **E-Mail:** ______
Home Mobile

Address: ______ ______ ___ ______
Mailing Address City State Zip Code

Whom may we thank for referring you to our practice?
◯ Current Patient ◯ Dental Office ◯ Internet Search ◯ Insurance ◯ Other

Name of the person or office referring you to our practice: ______

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than the patient, or you are the parent or guardian of the patient.

The following is for: ◯ The patient's spouse ◯ The person responsible for payment ◯ Not applicable

Name: ______ ______ ___ ______
Last First MI Preferred Name

Gender: ◯ Female ◯ Male **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ **SS#:** ______ **Emergency Contact:** ______ ______
Name Phone

Phone: ______ ______ **E-Mail:** ______
Home Mobile

Address: ______ ______ ___ ______
Mailing Address City State Zip Code

Medical Information:

What is your estimate of your general health?
◯ Excellent ◯ Good ◯ Fair ◯ Poor

Have you ever had any complications following dental treatment?
◯ Yes ◯ No If yes, please explain: ______

Have you been admitted to a hospital or needed emergency care during the past 2 years?
◯ Yes ◯ No If yes, please explain: ______

Are you under the care of a physician?
◯ Yes ◯ No Name of Physician: ______ Phone: ______ Treatment: ______

Are you pregnant, nursing, or do you think you might be pregnant?
◯ Yes ◯ No

Medical Information:

Indicate which of the following conditions you have or have had. Please check those that apply:

☐ Allergy – Amoxicillin	☐ Cancer	☐ Mitral Valve Prolapse
☐ Allergy – Aspirin	☐ Chronic Pain	☐ Nervous Disorders
☐ Allergy – Codeine	☐ Diabetes	☐ Neurological Disorders
☐ Allergy – Iodine	☐ Dizziness	☐ Osteoporosis
☐ Allergy – Latex	☐ Epilepsy	☐ Pacemaker
☐ Allergy - Local Anesthetics	☐ Excessive Bleeding	☐ Pregnancy
☐ Allergy – Penicillin	☐ Fainting	☐ Radiation Treatment
☐ Allergy – Sedatives	☐ Glaucoma	☐ Respiratory Problems
☐ Allergy – Sulfa	☐ Head Injuries	☐ Rheumatic Fever
☐ Anemia	☐ Heart Attack	☐ Rheumatism
☐ Angina	☐ Heart Disease	☐ Sexually Transmitted Disease
☐ Arteriosclerosis	☐ Heart Murmur	☐ Sinus Problems
☐ Arthritis	☐ Hepatitis	☐ Sleep Disorder
☐ Artificial Joints	☐ High Blood Pressure	☐ Stomach Problems
☐ Asthma	☐ HIV-AIDS	☐ Stroke
☐ Autoimmune Disease	☐ Kidney Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Liver Disease	☐ Tobacco/Alcohol Use
☐ Blood Thinner	☐ Low Blood Pressure	☐ Tuberculosis
☐ Blood Transfusion	☐ Mental Disorders	☐ Tumors
☐ Bronchitis	☐ Migraines	☐ Ulcers

Do you have any disease, condition, or problem not listed above that you think we should know about?

◯ Yes ◯ No If yes, please explain: ______________________________

List all medications you are currently taking (prescription and non-prescription): ______________________________

____

____

Consent for Services and Financial Policy:

I acknowledge that I have reviewed this form and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify Coral Springs Family Orthodontics of any future changes.

As a condition of treatment by this office, financial arrangements must be made in advance. Coral Springs Family Orthodontics depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged to the patient and that he or she is personally responsible for payment of all dental services. Coral Springs Family Orthodontics will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. I understand that in case a refund is required, it will take between 2 and 3 business days.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

______________________________ Relationship to Patient: ______________________ Date: ______________

Signature of patient, parent/guardian, or responsible party

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH IMFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

*CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with ***CORAL SPRINGS FAMILY ORTHODONTICS.,*** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de **CORAL SPRINGS FAMILY ORTHODONTICS., y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient Name: *(please print)* ____________________
Nombre Del Paciente: *(nombre en letra de molde por favor*

Patient Signature *(or legal representative; proof may be requested)* ____________________
Firma Del Paciente: *(o representante legal; prueba puede ser requerida)*

Date: *(dd/mm/yy)* ____________________
Fecha: *(dd/mm/aa)*

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM *CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **CORAL SPRINGS FAMILY ORTHODONTICS., (CSFO)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **CSFO** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **CSFO** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **CSFO** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **CORAL SPRINGS FAMILY ORTHODONTICS., (CSFO)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **CSFO** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **CSFO** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **CSFO** y yo consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

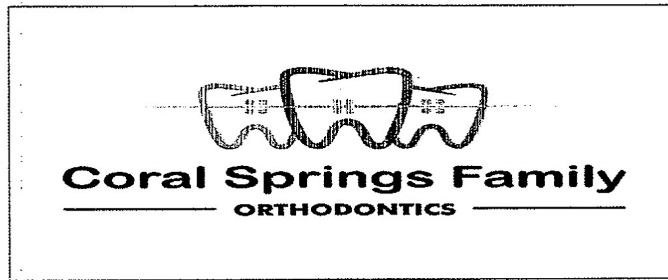
My Consented Email Address is: ____________________
***Mi Correo Electrónico Consentido es:**

My Consented for Text Messaging to: ____________________
***Mi Mensaje de Textos Consentido a:**

X____________________
Patient Signature *** Firma del Paciente**

____
Date *Fecha

In Case of Any Emergency Please Call 911 or Proceed to the Nearest Emergency Room, DO NOT USE THIS WAY OF COMMUNICATION FOR THAT PURPOSE.
En Caso de Cualquier Emergencia Por Favor Llame al 911 o Proceda al Centro de Emergencia Cercano, NO USE ESTA FORMA DE COMUNICACIÓN PARA ESE PROPOSITO



CANCELLATION & BROKEN APPOINTMENT POLICY

Date: ______________________

Coral Springs Family Orthodontics will charge a $40.00 fee for any missed and/or cancelled appointments without 24-hour advanced notice.

I agree to pay a $40.00 fee if I fail to give 24-hour advanced notice for a scheduled visit with my doctor.

Print Name: ____

Signature: ____