New Braunfels Orthodontic Associates

230 Hunters Village
New Braunfels, TX 78132
830.625.0414
info@foundmysmile.com
www.foundmysmile.com

1. *Patient Information:

First Name: _____ Last Name: _____ Middle Initials: _____

Date of Birth: _____ Gender: ○ Female ○ Male

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Occupation: _____ Patient interest or hobbies: _____

2. Responsible Party (if different from previous listing):

First Name: _____ Middle Initials: _____ Last Name: _____

Gender: ○ Female ○ Male

Date of Birth: _____

Marital Status: ○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Email: _____

Preferred contact method: ○ Mobile Phone ○ Email

3. *Family Referral:

Are any of your family members active or previous patients of Dr. Layfield?
○ Yes ○ No

If yes, what is the Patients Name: _____

Do you have any children who would possibly need a complimentary exam in the future? if so, please list name and ages: _____

4. *How did you hear about our office?

○ Dentist Referral ○ Family/Friend Referral ○ Google Search
○ Community Event

Please name either the Dentist or Family/Friend that referred you; If you met us at a community event please tell us which one.

_____

5. *General Dentist Information:

Have you had a dental visit in last 6 months?
○ Yes ○ No

Dentist Name: _____

6. *What treatment option(s) are you interest in?

☐ Invisalign ☐ Traditional Braces ☐ Retainers

INSURANCE STANDARD

We ask that you realize we don't work for an insurance company, but we do work 100% for our patients. Most insurance companies provide great benefits for our patients and we're going to do everything we can to maximize your benefits. Please understand that the fees we charge and the treatment that we're going to recommend is specifically designed for your individual needs and never based on your insurance coverage.

7. *Do you have Orthodontic Insurance?

○ Yes ○ No

If yes, please complete the Dental Insurance section below

8. Primary Dental Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Policy Holder First and Last Name _____ Patient Relationship to Insured ○ Self ○ Spouse ○ Other

Insured Date of Birth _____ Policy Holder Employer _____

Insured Street Address _____ City _____ State _____ Zip Code _____

Insured Contact Number _____

9. Secondary Dental Insurance (optional)

Secondary Insurance Company | Member ID / Policy # | Group Number

Policy Holder First and Last Name

Patient Relationship to Insured
○ Self ○ Spouse ○ Other

Insured Date of Birth | Policy Holder Employer

Insured Street Address | City | State | Zip Code

Insured Contact Number

10. Have you previously had orthodontic treatment?

○ Yes ○ No

11. *What is your primary concern(s)?

12. *Patient History

Does the patient have any allergies? If yes, please list below:

Please list any medication the patient is currently taking:

13. Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Asthma/COPD
- ☐ Bleeding abnormally
- ☐ Cancer Treatment
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ GERD/Acid Reflux
- ☐ Headaches/Migraines
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV AIDS
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Tobacco use

Other/Details:

14. Indicate any history of (check all that apply); If checked "Yes", please explain.

- ☐ Thumb/finger sucking
- ☐ Tongue and/or swallowing problems
- ☐ Speech problems
- ☐ Loose teeth or broken fillings
- ☐ Grinding and/or clenching of teeth
- ☐ Tonsils and adenoids removed
- ☐ Crowns/Bridges
- ☐ Root canals
- ☐ Mouth breathing
- ☐ Snoring
- ☐ History of wearing a mouthguard at night
- ☐ History of Periodontal disease
- ☐ History of Periodontal treatment
- ☐ Mouth sores
- ☐ Injury to face or teeth
- ☐ Jaw Pain
- ☐ Clicking or popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ Sensitivity when biting
- ☐ Cold, hot, or sweets sensitivity certain teeth
- ☐ Food collection between

Other/Details:

_____

15. Have you had any serious illnesses or operations? If yes, please describe.

_____

16. Is there anything else you would like us to know before your visit?:

_____

_____

_____

_____

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

_____ _____

Signature Date

New Braunfels Orthodontic Associates FoundMySmile.com

Larry L. Layfield, D.D.S.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of, your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date:

Patient Name:

Relationship to Patient:

Signature:_____

New Braunfels Orthodontic Associates
230 Hunters Village
New Braunfels, TX, 78132
Foundmysmile.com
Privacy Officer Phone: 210-616-2030
Privacy Officer Email: admin@hcr-audit.com

Authorization for Use or Disclosure of Protected Health Information

I hereby voluntarily authorize the disclosure of information from my health record. I understand that I may revoke this authorization at any time in writing and submitted to the Covered Entity above, except to the extent that action has been taken in reliance on this authorization.

_____
Name of Patient

_____ _____
Signature of Patient, Parent (if patient is a minor), or Legal Representative Date

The information from my health record is to be disclosed by the Covered Entity above and provided to the following:

_____ _____
Name of Person/Organization Name of Person/Organization

_____ _____
Street Address Street Address

_____ _____
City/State/ZIP City/State/ZIP

The information to be disclosed from my health record is limited to (check):

☐ Only information related to: _____

☐ Only for the period from: _____ to _____

☐ Entire health record