



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date: _____ Male Female
Name: _____ Nickname: _____
Last First MI
Home Address: _____
Street Apt # City State Zip
Home Phone: (____) _____ Work Phone: (____) _____
Birthdate: ____/____/____ Age: _____ Hobbies/Sports: _____
mm dd yyyy
School: _____ Grade: _____
Hobbies/Sports: _____ Whom may we thank for referring you? _____
General Dentist: _____ Last Cleaning Date: _____
Is all dental work completed: Yes No
Orthodontic Concerns: _____

Who Is Accompanying Your Child Today?

Name: _____ Relationship to Child: _____
Do you have legal custody of this child? Yes No
Who is responsible for scheduling appointments? _____
Home Phone: (____) _____ Work Phone: (____) _____

Responsible Party Information

Name: _____ Marital Status: _____
Last First MI
Residence: _____
Street Apt # City State Zip
Mailing Address: _____
Street Apt # City State Zip
How long at this Address? _____ Home Phone: (____) _____ Work Phone: (____) _____
Cell Phone: (____) _____ E-mail: _____
Birthdate: ____/____/____ Social Security Number: _____ Relationship to Patient: _____
mm dd yyyy
Employer: _____ Occupation: _____ No. Years Employed: _____
Spouse's Name: _____ Relationship to Patient: _____
Birthdate: ____/____/____ Social Security Number: _____ Relationship to Patient: _____
mm dd yyyy
Employer: _____ Occupation: _____ No. Years Employed: _____

Insurance Information

Insured's Name: _____ Insured's Social Security #: _____
Insurance Company: _____ Group #: _____ Phone: (____) _____
Insured's Employer: _____
Do you have dual coverage? Yes No If yes:
Insured's Name: _____ Insured's Social Security #: _____
Insurance Company: _____ Group #: _____ Phone: (____) _____
Insured's Employer: _____

Consent for use and Disclosure of Health Information

Patient Giving Consent:

Name: _____

Address: _____

Telephone: _____ E-mail: _____

If patient is a minor, Patient's Parent/Guardian's name: _____

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 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 protected health information. You have previously received a copy of our notice.

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, 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 the office.

Phone: (407) 656-0990 Fax: (407) 656-6648 E-mail: info@championorthodontics.com

Address: 3311 Daniels Rd, Suite 104, Winter Garden, FL 34787

Signature:

I, _____, have had the full opportunity to read and consider the contents of this Consent form and your Notice of Private Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of the patient's 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: _____

You are Entitled to a Copy of this Consent after You Sign it



Consent For Use Of Photograph

By signing this form, you will consent to our use of you photograph within our office. This is including our office newsletter, picture board, and office display. Your photograph will not be used or distributed to any other organizations.

Patient's Name: _____ Date: _____

Signature: _____

You have the right to revoke this consent at any time by giving us written notice of revocation

Revocation of Consent:
I do not give Consent for use of my Photographs

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient's Name: _____ Date: _____

Signature: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- _____ Individual Refused to Sign
- _____ Communication Barriers Prohibited Obtaining the Acknowledgement
- _____ An Emergency Situation Prevented us from Obtaining the Acknowledgement
- _____ Other (Please Specify)

