



We would like to welcome you to our office. Our goal is to make every patient's visit pleasant and educational

**Tell Us About Yourself**

Today's Date: \_\_\_\_\_  Male  Female

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Last First MI

Home Address: \_\_\_\_\_  
Street Apt # City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_  
mm dd yyyy

Whom may we thank for referring you? \_\_\_\_\_ Hobbies/Sports: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Last Cleaning Date: \_\_\_\_\_

Is all dental work completed:  Yes  No

Orthodontic Concerns: \_\_\_\_\_

**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: \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
Street Apt # City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

**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](mailto: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: \_\_\_\_\_

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## 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

