**BYRNE ORTHODONTICS**

**PATIENT HISTORY UPDATE**

**Name** _____ **DOB** _____ **Date** _____/ _____/ _____

**The following questions are designed to update your health history, insurance and personal information, and to make us aware of any changes regarding your appointments in our office:**

**Does the patient have or has the patient had any of the following? (Please check all that apply.)**

| | | | | |
|---|---|---|---|---|
| ☐High/Low Blood Pressure | ☐Diabetes | ☐Asthma/Hay Fever | ☐ Jaundice | ☐Rheumatic Fever |
| ☐Venereal Disease | ☐Epilepsy | ☐Aids/HIV | ☐Hepatitis | ☐Arthritis |
| ☐Fainting Spells/Seizures | ☐Radiation Therapy | ☐Heart Trouble | ☐Stomach Ulcer | |

**☐Yes ☐No Is the patient pregnant? Due date:** _____
**☐Yes ☐No Does patient require antibiotics prior to treatment? If yes, please describe** _____
**☐Yes ☐No Has there ever been trauma to patient's face/teeth? If yes, please describe** _____
**☐Yes ☐No Is the patient presently under the care of a physician for an illness or disease?**
**If yes, please describe** _____
**☐Yes ☐No Does the patient have a bleeding tendency or do wounds heal slowly?** _____
**☐Yes ☐No Is the patient allergic to nickel, latex or any drugs or medications?**
**If yes, please describe** _____
**☐Yes ☐No Is the patient taking any medications? If yes, please describe** _____

**☐Yes ☐No Do you have dental insurance?**
**If yes, please complete the insurance form.**

**Responsible Party Name** _____ **Relationship** _____
**Mailing address** _____
**Primary #** _____ **Work #** _____ **Emergency #** _____
**E-mail address** _____

**Other than responsible party, who else can bring patient to appointment, discuss financial or schedule appointments?**

**Name** _____ **Relationship** _____
**Name** _____ **Relationship** _____

**To the best of my knowledge, the questions on this update form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform Byrne Orthodontics of any changes in my medical status. I also authorize Byrne Orthodontics to perform any necessary orthodontic services that I may need.**

_____ _____
**Patient/Responsible Party Signature** **Date**

**Patient consent for use and disclosure of protected health information**
**I have read and received the Notice of Privacy Practices and hereby give my consent for Byrne Orthodontics to use and disclose health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO).**

_____ _____ _____
**Please print name** **Patient/Responsible Party Signature** **Date**

**BYRNE ORTHODONTICS**

**INSURANCE FORM**

**Date _____**

*****This is NOT a guarantee of benefits or payment. Actual benefits cannot be determined until actual claim is received by carrier. As per contract patient is responsible for any balance denied or rejected by insurance carrier *****

**Patient Name: _____**

**Patient's Date of Birth: _____/ _____/ _____**

**Policy Holder's Name: _____ Policy Holder Birth Date _____**

**Policy Holder's Address _____ Zip Code _____**

**Employer: _____**

**Dental Insurance Company:_____**

**Insurance Co. Phone Number: _____**

**Effective date of New Insurance: _____**

**Policy Holder ID Number or Social Security Number: _____**

**Group Number: _____**

☐ **Copy of Insurance card attached**

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## INFORMATION AND PAYMENT AUTHORIZATION RELEASE

**I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment.**

_____ _____

**Signature (responsible party)** **Date**

**I hereby authorize payment directly to Byrne Orthodontics of the group insurance benefits otherwise payable to me.**

_____ _____

**Signature (responsible party)** **Date**