

WELCOME TO DR. YOREK'S OFFICE

Our office vision is to create beautiful smiles while providing a rewarding experience for every family.

To help us meet your entire healthcare needs, please fill out this form completely in ink.

Patient Information (Confidential)

Date _____ Date of Birth _____ Age _____ Sex _____

Patient Name _____ Home Phone _____
Last First Middle Init.

Address _____
Street City State Zip code

E-mail Address _____ School _____ Grade _____
Patient's Dentist _____ Physician _____

Names and Ages of Children In Family _____

Whom may we thank for referring you to our office? _____

If patient is a minor, give parent or guardian's name _____

Responsible Party/Custodial Parent/Legal Guardian Information

Name of Person Responsible for this Account _____
Last First Middle Initial

Billing Address _____
Street City State Zip code

Home Phone _____ Relationship to patient _____ Marital Status _____

Employer _____ Occupation _____ Work Phone _____

Number of Years Employed _____ Social Security # _____ Birth date _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ Work Phone _____

Number of Years Employed _____ Social Security # _____ Birth date _____

Third Party Responsible for this Account _____
Last First Middle Initial

Billing Address _____ Home Phone _____
Street City State Zip

Relationship to Patient _____ Marital Status _____ Birth date _____

Employer _____ Occupation _____ Work Phone _____

Numbers of Years Employed _____ Social Security # _____ Birth date _____

Emergency Contact Information

Name of Emergency Contact Person (other than those listed above) _____

Address _____
Street City State Zip code

Primary Phone _____ Secondary Phone _____

Patient Medical History

Are you in good health? Yes ___ No ___ Do you have a history of a major illness? Yes ___ No ___
Have you ever been under the care of a physician for illness? Yes ___ No ___ If yes, explain _____

Check any of the following for which you have been treated:

- Diabetes ___ Bone Disorders ___ Asthma ___ Fainting or Dizziness ___ Pneumonia ___
- Epilepsy ___ Tuberculosis ___ Kidney Involvement ___ Nervous Disorders ___ Heart Trouble ___
- Anemia ___ Endocrine Problems ___ Liver Involvement ___ Rheumatic Fever ___ Prolonged Bleeding ___

Have you ever tested positive for Acquired Immune Deficiency Syndrome? Yes ___ No ___
Do you have a tendency to colds? Yes ___ No ___ Sore throats? Yes ___ No ___ Ear Infections? Yes ___ No ___
Have tonsils and adenoids been removed? Yes ___ No ___ If yes, what age? _____
List any drugs or medications now being taken. Please give reasons: _____

List any allergies or drug sensitivity: _____
Height _____ Weight _____

Dental History

Have there been any injuries to the face, mouth, or teeth? Yes ___ No ___ If yes, explain _____
Have you ever sucked a thumb or fingers? Yes ___ No ___ Until what age? _____
Do you have any speech problems? Yes ___ No ___
Are you a mouth breather? While awake? Yes ___ No ___
While asleep? Yes ___ No ___
Have you been informed of any missing or extra permanent teeth? Yes ___ No ___
Has an orthodontist been consulted previously? Yes ___ No ___
Has either parent had orthodontic treatment? Yes ___ No ___
List any musical instruments played: _____
Reason for consultation: _____
When was your last dental checkup? _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form be kept confidential. The federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations. Examples are available upon request. Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or at work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent we have already taken actions relying on your authorization.

For more information about our Privacy Practices, please contact our office.

I have reviewed Dr. Yorek's Notice of Privacy Practices and understand that more information is available upon request. I also certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately; I understand that providing incorrect information can be dangerous to my health. I authorize to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such orthodontic or dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I understand that my orthodontic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize that Dr. Daryl Yorek and staff of his practice to provide orthodontic treatment to the patient listed on this form.

X _____ Date _____
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR)