



dr. stuart frost

A Future Full of Smiles, Let It Begin With Us

PATIENT INFORMATION

Patient's name, Birthdate, Social Security #, E-Mail, Home Address, City, State, Zip, How long at this address?, Home Phone, School, Grade, If patient is a minor, give custodial parent's name or guardian's name, Patient's hobbies, General Dentist, Dentist Phone, Who may we thank for referring you to our office?

RESPONSIBLE PARTY INFORMATION

Primary, Marital Status, E-Mail, Home Address, Own, Rent, City, State, Zip, How long at this address:, Home Phone, Work Phone, Cell Phone, Social Security #, Birthdate, Relationship to patient, Employer, Occupation, # years employed, Secondary, Marital Status, E-Mail, Home Address, Own, Rent, City, State, Zip, How long at this address:, Home Phone, Work Phone, Cell Phone, Social Security #, Birthdate, Relationship to patient, Employer, Occupation, # years employed

DENTAL INSURANCE INFORMATION

Insured's Name, Insurance ID #, Insured's Birthdate, Relationship to patient, Insurance Company, Phone #, Employer, Group #, Do you have dual coverage? YES NO If yes, please complete the following section: Insured's Name, Insurance ID #, Insured's Birthdate, Relationship to patient, Insurance Company, Phone #, Employer, Group #

EMERGENCY INFORMATION

Name of nearest relative not living with you, relationship, Address, Home phone, City, State, Zip, Work phone

I understand that the information I have given is correct and I authorize the dental staff to perform the necessary dental services my child may need. I understand where appropriate, credit bureau reports may be obtained.

Signature(parent/guardian if minor)

Date

YES	NO
Mother	Father

- Have any primary/permanent teeth been removed by extraction?
- Has patient been ridiculed about the appearance of his/her teeth?
- Would patient mind wearing braces?
- Has a dentist ever placed a retainer or space maintainer?
- Does anyone in the family have similar dental conditions as the patient?
- Is patient adopted?
- Does the patient resemble mother or father more? (Please circle one)

What are your main concerns that you would like Dr. Frost to address? _____

Frost Orthodontics
Patient Privacy Consent

This form is Optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign, and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations. (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's private notice prior to signing this copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not requested to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's Signature/Parent or Guardian Signature

Print Name

Date