www.drkristengeorge.com
info@drkristengeorge.com
502-425-3350

GEORGE
ORTHODONTICS
DR. KRISTEN E. GEORGE

10412 Shelbyville Road
Louisville, KY 40223

5225 Dixie Highway
Louisville, KY 40216

Adult Patient Information

TODAY'S DATE ______________________________

PATIENT INFORMATION

PATIENT NAME ____________________________________ DATE OF BIRTH ________ AGE __________ SEX M ☐ F ☐

PHONE # ____ STREET ADDRESS ____________________________________

CITY ____ STATE _____________________ ZIP ____________________

EMPLOYER _______________________________________ OCCUPATION _______________________________________

GENERAL PHYSICIAN _______________________________ PHYSICIAN PHONE # ________________________________

PATIENT EMAIL ____

PRIMARY REASON FOR VISIT ____

INSURANCE INFORMATION

DO YOU HAVE ORTHODONTIC INSURANCE COVERAGE Y ☐ N ☐

SUBSCRIBER NAME _________________________________ DATE OF BIRTH _____________________________________

RELATIONSHIP TO PATIENT _________________________ SOCIAL SECURITY # __________________________________

NAME OF ORTHODONTIC INSURANCE PROVIDER ____

INSURANCE CO. MAILING ADDRESS ____

SUBSCRIBER EMPLOYER____

INSURANCE CO. PHONE #____

GROUP# __________________________________ MEMBER ID #____

I AUTHORIZE THE RELEASE OF ANY INFORMATION TO THE INSURANCE COMPANY ______________________________
(Signature)

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Patient Signatures

I confirm all information stated to be correct to the best of my knowledge. I understand it is my responsibility to notify George Orthodontics of any changes in my health history.

SIGNATURE ____ DATE ______________________

PURPOSE OF CONSENT

By signing this form, you 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 document 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 your protected health information. A copy of our notice accompanies this consent.

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 of Privacy Practices document, 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 our office.

RIGHT TO REVOKE

You have the right to revoke this consent at any time by giving the George Orthodontics office written notice of your revocation. Please understand that revocation of this consent will not affect any action taken in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, ____ have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices document. I understand that, by signing this consent form, **I give my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.**

SIGNATURE ____ DATE ______________________