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

Child Patient Information

TODAY'S DATE _____

PATIENT INFORMATION

PATIENT NAME _____

DATE OF BIRTH _____ AGE _____ SEX M F

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____

SCHOOL _____

INTERESTS/ACTIVITIES _____

DATE OF LAST DENTAL CLEANING _____

DENTIST _____ PHONE _____

PHYSICIAN _____ PHONE _____

HOW DID YOU HEAR ABOUT US _____

MAY WE TEXT YOU Y☐ N☐

WHO IS WITH THE CHILD TODAY *(IF APPLICABLE)*

NAME _____ RELATIONSHIP _____

ARE THERE OTHER FAMILY MEMBERS IN TREATMENT HERE

_____

IF YES, NAME(S) / AGE(S) _____

_____

WHAT DO YOU HOPE TO ACCOMPLISH WITH BRACES

_____

HAS THE PATIENT SEEN ANOTHER ORTHODONTIST Y☐ N☐

NAME OF PERSON RESPONSIBLE FOR FINANCIAL ACCOUNT

_____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

PRIMARY RESPONSIBLE PARTY

NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL # _____ HOME # _____

EMAIL _____

EMPLOYER _____

OCCUPATION _____

SECONDARY RESPONSIBLE PARTY *(IF APPLICABLE)*

NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL # _____ HOME # _____

EMAIL _____

EMPLOYER _____

OCCUPATION _____

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RESPONSIBLE ADULT NAME / RELATIONSHIP _____ **DATE** _____

Insurance Information

DO YOU HAVE ORTHODONTIC INSURANCE COVERAGE Y ☐ N ☐

IF YES, NAME OF ORTHODONTIC INSURANCE CENTER _____

INSURER MAILING ADDRESS _____

SUBSCRIBER NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

GROUP # _____ MEMBER ID # _____ INSURANCE CO. PHONE # _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

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

Signature of Parental or Guardian Consent

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 child's 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 am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE _____ DATE _____