345 W Iowa Ave
Nampa, ID 83686
208-467-4362

CHRIS CUSIMANO DDS, MS
ORTHODONTICS

PATIENT INFORMATION:

Name: ____
First Middle Initial Last Nickname

Address: ____________________________ City: ______________ State: ________ Zip: ____________

DOB: __________________ Patient Email: ____

Phone 1: ____________________ Phone 2: ____________________ Phone 3: ____________________
home cell work

School: ____

Whom may we thank for referring you? _______________________________________

Dentist: ____
Name Phone Number

RESPONSIBLE PARTY INFORMATION:

Name: ____
First Middle Initial Last Relationship to Patient

Address: ____________________________ City: ______________ State: ________ Zip: ____________

Email: ____________________________ Prefer email or text notification for appointments: ______________

Phone 1: ____________________ Phone 2: ____________________ Phone 3: ____________________
home cell work

DOB: ____________________ Social Security #: ______________________________________

How long at this address: __________ Previous Address if less than 3 years: ______________________________

SPOUSE:

Name: ____
First Middle Initial Last Relationship to Patient

Address: ____________________________ City: ______________ State: ________ Zip: ____________

Email: ____

Phone 1: ____________________ Phone 2: ____________________ Phone 3: ____________________
home cell work

DOB: ____________________ Social Security #: ______________________________________

INSURANCE INFORMATION:

Primary Insured's Name: ____________________________ DOB: ____________ Soc. Sec.: ______________

Insured's Employer: ____

Insurance Company: ____________________ Address: ____________________ Phone#: ____________

Secondary Insured's Name: ____________________________ DOB: ____________ Soc. Sec.: ______________

Insured's Employer: ____

Insurance Company: ____________________ Address: ____________________ Phone#: ____________

MORE INFORMATION TO COMPLETE ON BACK SIDE

Emergency Information:

Emergency Contact's Name: ____

Address: ______________________________ City: __________________ State: ________ Zip: ___________

Phone: ______________________________ Relationship to Patient: ______________________________

Medical Information:

Is the patient experiencing any health problems? Yes _____ No _____ Reason: ______________________

Any major or unusual illnesses? Yes _____ No _____ Reason: ______________________

Currently under Physician's care? Yes _____ No _____ Reason: ______________________

Currently taking any medication or supplements? Yes _____ No _____ List: ______________________

Allergies? Yes _____ No _____ List: ______________________

Drug Sensitivity? Yes _____ No _____ List: ______________________

Has the patient ever received a blood transfusion? Yes _____ No _____ Reason: ______________________

Does the patient have a cardiovascular condition that requires pre-medication prior to certain procedures? Yes ________ No ______

Please circle if patient has or has had any of the following:

Anemia	Blood Disease	Prolonged Bleeding	Frequent Colds or Flu
Rheumatic Fever	Heart Murmur	Tuberculosis	Jaundice
Epilepsy	Herpes	Hepatitis	Been in risk group for Aids
HIV/Aids	Diabetes	Asthma	Endocrine (hormone) Problems
Tonsillitis	Adenitis	Bone Disorders	ADHD

Tonsils Removed? ______________________ Age __________ Adenoids removed? ______________________ Age _________

Mouth Breathing? While awake, while asleep, or both? ______________________________

Has the patient had any severe head or face injuries? If yes, explain ______________________________

History of thumb/finger sucking? If yes, habit still present or what age did it stop? ______________________________

Any previous Orthodontic Treatment? ______________________ Any history of Orthodontic Treatment in the family? ______________________

Please circle if patient has a history:

Clenching teeth	Grinding teeth	Ringing in ears	Jaw joint popping
Jaw joint clicking	Jaw joint soreness	Headaches (frequent)	Muscular soreness around head/neck

I understand that if I proceed with records for appliances and do not follow through with treatment; I am responsible for the cost of the records. ____

Signature of Patient/Parent or Guardian

I give my consent for Dr. Cusimano and staff to perform an Orthodontic Examination on me/my child.

____

Signature of Patient or Parent/Guardian if patient is a minor Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Patient Name: ____ Date : ____________________

Patient/Parent/Legal Guardian Signature: ____

I acknowledge that I have had the opportunity to review a copy of Dr. Chris Cusimano Orthodontic's Notice of Privacy Practices.

******OFFICE USE ONLY******

The office of Dr. Chris Cusimano has attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

_______ **Individual Refused to Sign**

_______ **Communication barriers prohibited obtaining a signature**

_______ **An emergency situation prevented us from obtaining a signature**

_______ **Other (please specify):** ____

IMAGE CONSENT FORM

Patient Name: ____

I consent to my image(s) appearing in Dr. Chris Cusimano prospects, brochures, literature, press, website, Facebook and other forms of social media, and any other promotional material relating to Dr. Chris Cusimano Orthodontics. For the avoidance of any doubt, I agree to assign to Dr. Chris Cusimano Orthodontics any intellectual property rights and to waive any moral or performing rights I may have or acquire by reason of my participation in such promotional material.

I understand that I can withdraw the consent at any time by writing to Dr. Cusimano Orthodontics and that such withdrawal of consent shall not affect any orthodontic treatment which has taken place or will take place and shall not affect my right to remain a patient of Dr. Chris Cusimano.

____   ___________________________

Patient or if a minor Parent/Legal Guardian Signature   Date