

Patient Information / HIPPA

Brian Reising, DDS, MS
Orthodontic Specialist

traditional and ceramic / clear braces
implant assisted orthodontics
hidden / lingual braces
surgical orthodontics
invisalign



Patient Name _____
Patient's preferred first name or nickname _____
Gender _____
Address _____
City _____
State, Zip _____
Home Phone _____
Work Phone _____
Mobile Phone _____
Email _____
Occupation/School _____
If Minor, Patient's Mother's Name _____

Records _____
Bonding _____
Date of Birth _____
Dentist's name: _____
Date of last dental check-up or cleaning: _____
How did you hear about us? _____
Who may we thank for referring you? _____
Other friends or family who are patients here? _____
Please describe the reason(s) you seek orthodontic treatment _____
If Minor, Patient's Father's Name _____

Responsible Party(s) "if different from above"
Name(s) of financially responsible party(s) / legal guardian(s)

Primary
Name _____
Relation to patient _____
Address _____
City _____
State & Zip _____
Home Phone _____
Work Phone _____
Mobile Phone _____
Email _____
Date of Birth _____
Social Security # _____
Employer _____

Secondary
Name _____
Relation to patient _____
Address _____
City _____
State & Zip _____
Home Phone _____
Work Phone _____
Mobile Phone _____
Email _____
Date of Birth _____
Social Security # _____
Employer _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I am stating that I have received a copy of Reising Orthodontics' Notice of Privacy Practices.
You May Refuse to Sign This Acknowledgement

Signature: _____ Date: _____