Patient Information Form

Patient Name: _____ Today's Date: _____

Preferred Name: _____ Gender: _____ Date of Birth: _____ Age: _____

Email: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ School: _____ Grade: _____

Who else have we treated in your family? _____

How did you hear about our office or who referred you? _____

Responsible Party: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: ___ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Spouse or Other Parent: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: ___ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Primary Dental Insurance

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone #_____

Member ID#_____ Group #_____ Insured's Employer: _____

Secondary Dental Insurance (if applicable)

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone #_____

Member ID#_____ Group #_____ Insured's Employer: _____

Consent to Exam

I understand that a pre-treatment exam and records are necessary before an orthodontist can make any specific treatment recommendations for my care. Pre-treatment records include a panoramic x-ray, facial and intra-oral digital photographs and a digital scan. I hereby consent to this complete orthodontic examination and to the taking of any necessary pretreatment records.

Name: _____ Signature: _____ Date: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Cofidential Patient Health History

Medical History

Primary Physician: _____ Phone: _____ Approximate date of last dental cleaning: _____

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Please confirm whether or not the patient has been treated for any of the following:

☐ Yes ☐ No Heart Conditions (murmur, etc.)	☐ Yes ☐ No HIV Positive	☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Excessive Bleeding	☐ Yes ☐ No Tuberculosis	☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Asthma	☐ Yes ☐ No Kidney Infections
☐ Yes ☐ No Rheumatic Fever	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Cerebral Palsy
☐ Yes ☐ No Liver Problems	☐ Yes ☐ No Birth Defects	☐ Yes ☐ No Eyesight Problems
☐ Yes ☐ No Cancer	☐ Yes ☐ No Infections	☐ Yes ☐ No Speech Impairments
☐ Yes ☐ No Nervous Disorders	☐ Yes ☐ No ADHD	☐ Yes ☐ No Autism
☐ Yes ☐ No Other_____		

Is the patient currently on any medications? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any foods or medicines? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any plastics or metals? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient taking or has the patient taken Bisphosphonates (e.g. Fosomax)? ..... ☐ Yes ☐ No

Does the patient need to be medicated prior to dental appointments? ..... ☐ Yes ☐ No

Have tonsils or adenoids been removed? ..... ☐ Yes ☐ No

Are you pregnant? ..... ☐ Yes ☐ No

Dental and Orthodontic History

General Dentist (name of office): _____ Approximate date of last dental cleaning _____

Is there any dental work to be completed? (Fillings,crowns, etc.). ☐ Yes ☐ No _____

Have there been any injuries to the face, mouth, or teeth? ☐ Yes ☐ No _____

Has the patient ever sucked their fingers or thumb? ☐ Yes ☐ No Until what age? _____

Does the patient have any speech problems? ☐ Yes ☐ No _____

Is the patient a mouth breather while asleep or awake? ☐ Yes ☐ No _____

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No _____

Is there pain/popping/clicking in the jaw joint? ☐ Yes ☐ No When did this begin? _____

Does the patient clench or grind? ☐ Yes ☐ No _____

Does the patient regularly have headaches? ☐ Yes ☐ No _____

Does the patient gag easily? ☐ Yes ☐ No _____

Has the patient ever had orthodontic treatment? ☐ Yes ☐ No _____

Has the patient ever had a previous orthodontist exam? ☐ Yes ☐ No _____

Have any family members had orthodontic treatment? ☐ Yes ☐ No _____

What is the chief concern that brought you to our office? _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Health History Update

Patient Initial: _____ Date: _____

Doctor: _____ Date: _____

General Consent and Practice Policy

The doctors and staff at this practice are committed to our patient's superior oral health. We follow scientific and ethical principles in order to provide our patients with the highest standard of orthodontic care. We try to create a fun, friendly and comfortable environment and we work hard to keep overall treatment length and appointment times to an absolute minimum. We know you have a choice in orthodontic providers and we hope that these goals are the primary reasons you have chosen our practice. The following practice policies help reinforce these guiding principles.

_____ **Payment/Insurance Policy:** Unless other payment options are arranged through a signed contract with the office, payment in full is due at the time of service. We accept all major credit cards, cash, or personal checks. Credit card payments are subject to a surcharge of _____ We cannot guarantee any estimated coverage when billing insurance. Patients are responsible for determining if their insurance is contracted for the services that will be provided. Patients are responsible for any remaining balance not paid by insurance. There will be a $50 service fee on any returned checks. All unpaid balances are subject to a 10% processing fee. All delinquent balances must be paid prior to incurring any new charges and are subject to a late payment fee of $25. Any service overpaid will automatically be refunded to the patient's original payment method within 60 days. Checks will be issued within 60 days from the payment date for patients who made a cash payment.

The insurance coverage is only an estimate. Should the figure differ, the balance will be assumed by the responsible party. If your insurance company pays you directly, you will need to reimburse the office within 30 days of receipt of the check. If reimbursement is not received within 30 days, the balance of the check will be assumed your responsibility. Orthodontic benefits paid through your insurance are rarely paid in one lump sum. They are generally paid throughout the length of treatment

_____ **Missed or Canceled Appointment Policy:** Due to the busy nature of our practice and as a courtesy to the doctors and staff who are providing care, we ask that you please make your appointments a top priority. If you are unable to make the scheduled appointment, please give us sufficient notice to be able to fill the appointment slot. We ask that you call to reschedule or cancel at least 24 hours in advance. If you miss or break your appointment with less than 24 hours notice, you may be subject to a cancellation fee up to $100. A second last minute cancellation or no-show may lead to the end of the doctor-patient relationship.

_____ **Late Appointment Policy:** We ask that patients be on time for all scheduled appointments in order to fully utilize their appointment time and minimize the impact to other patients scheduled that day. If a patient is more than 10 minutes late to an appointment they may be required to reschedule or asked to wait until after the on-time patients have been seen. Regular tardiness may lead to the end of the doctor-patient relationship.

_____ **Consent to Treat Policy:** I give permission for the practice to perform orthodontic procedures within the scope of dentistry as deemed necessary. I acknowledge that every orthodontic case is unique and understand that occasional adjustments to the original treatment plan may be necessary to achieve the best result. I authorize the provider to use their professional judgment for procedures in addition to or different from those originally contemplated. I have provided as accurate and complete medical history as possible including those antibiotics, drugs, medications, and foods to which my child is allergic.

I give my permission to the following individuals to bring in my child/children to the practice for their appointments that may include any and all dental procedures. List names here: _____

_____ **Aligner Non-Compliance:** You could be charged for converting to brackets due to non-compliance will result in a fee of $1,250. Additionally, if you decide to decline Invisalign treatment after contracting service, you may be liable for the practice's lab fee.

_____ **Communication Policy:** Our top priority is to give you all the information needed to make informed decisions in regards to your/your child's oral health. This includes providing you with recommended procedures, the risks of those procedures, any treatment alterna-tives, and an estimate of the costs involved to perform those procedures. If you have any concerns about our treatment or policies, please bring them immediately to our attention so that we can resolve any questions and continue to develop a long-term relation-ship where your/your child's oral health and dental experience is number one for both of us.

_____ **Communication from Bluetree Brands:** I give my consent to receive relevant communication from Bluetree brands (parent company) and its affiliated partners.

_____ **Social Media/Image Consent:** I give consent to use images taken of me/my child to showcase the extraordinary care we have received.

_____ _____

Patient/Guardian's Signature | Date

_____ _____

Printed Name | Relationship to Patient, if applicable

_____ _____

Patient/Guardian's Name | Date

_____

Signature

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgment**

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices:

_____

Please Print Patient Name

_____

Signature of Patient/Legal Guardian

_____

Date

You may communicate with the following individuals relating to the patient's medical or payment information:

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgment of Receipt of our Notice of Privacy Practices was attempted, however acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)

_____