WELCOME

1 PATIENT INFORMATION

Today's Date _____

Patient's Full Name _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Home Address _____

City/State/Zip _____

Cell Phone Number _____

Home Phone Number _____

Email _____

Siblings/Age _____

Emergency Contact Name _____

Emergency Contact Phone _____

2 PARENT/GUARDIAN INFORMATION

(If the patient is over 18, please skip and continue to Section #3)

Parent's Marital Status:

☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Separated* ☐ *Widowed*

Parent: ☐ Mother ☐ Father ☐ Guardian ☐ StepParent

Full Name _____ Date of Birth _____

Address, if different _____

Phone Number _____

Email Address _____

Parent: ☐ Mother ☐ Father ☐ Guardian ☐ StepParent

Full Name _____ Date of Birth _____

Address, if different _____

Phone Number _____

Email Address _____

3 WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

☐ Dentist ☐ Family Member ☐ Facebook/Website ☐ Advertisement ☐ Insurance Company

☐ Friend Who Comes Here: _____ ☐ Other: _____

4 RESPONSIBLE PARTY INFORMATION

If the patient is a minor, who will be accompanying the patient to appointments and is responsible for this account

Full Name _____

Relationship to Patient _____

5 DENTAL INSURANCE INFORMATION

Primary Insurance

Subscriber Name _____

Date of Birth _____

Relationship to Patient _____

Insurance Company _____

Employer Name _____

Subscriber ID # _____

Subscriber SSN # _____

Insurance Group # _____

Insurance Phone # _____

Secondary Insurance

Subscriber Name _____

Date of Birth _____

Relationship to Patient _____

Insurance Company _____

Employer Name _____

Subscriber ID # _____

Subscriber SSN # _____

Insurance Group # _____

Insurance Phone # _____

NOTICE: Payment for all services rendered is due at time of treatment, unless the financial coordinator has approved prior arrangements. I understand that I am responsible for payment of services rendered and also responsible for paying and payment of deductibles that my insurance does not cover. I authorize payment of my group insurance benefits to be made directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examinations, to my insurance company.

Responsible Party Signature _____ **Date** _____

Medical History

Physician _____ City/Town _____

Are you currently taking any medications? If so, which? _____

_____

Are you allergic to any medications, latex or metals? _____

_____

Do you have a history of any major illnesses/operations? _____

_____

Have you ever been involved in a serious accident? _____

_____

DO YOU HAVE/HAVE A HISTORY OF:

Abnormal Bleeding/Hemophilia	YES	NO
ADD/ADHD	YES	NO
Anemia	YES	NO
Arthritis	YES	NO
Asthma/Hay Fever	YES	NO
Autism	YES	NO
Bone Disorders	YES	NO
Congenital Heart Defect	YES	NO
Diabetes	YES	NO
Dizziness/Vertigo	YES	NO
Epilepsy	YES	NO
Gastrointestinal Disorders	YES	NO
Heart Problems	YES	NO
Heart Murmur	YES	NO
Hepatitis	YES	NO
Herpes	YES	NO
High Blood Pressure	YES	NO
HIV/AIDS	YES	NO
Kidney Problems	YES	NO
Nervous Disorders	YES	NO
Pneumonia	YES	NO
Prolonged Bleeding	YES	NO
Radiation/Chemotherapy	YES	NO
Rheumatic Fever	YES	NO
Tuberculosis	YES	NO
Tumors/Cancer	YES	NO

Are there any medical conditions that we have not discussed that we should be aware of? _____

_____

_____

Dental History

Dentist _____ City/Town _____

Date of last dental exam _____

What concerns you most about your teeth? _____

_____

DO YOU HAVE/HAVE A HISTORY OF:

Dental Pain	YES	NO
Injuries to Face, Mouth, or Teeth	YES	NO
Bleeding Gums While Brushing	YES	NO
Mouth Breathing	YES	NO
Teeth or Jaw Soreness in Morning	YES	NO
Clenching Teeth During the Day	YES	NO
Lost or Chipped Permanent Teeth	YES	NO
Mouth Sensitivity to Temperature or Pressure	YES	NO
Thumb Sucking or Tongue Thrusting	YES	NO
Chronic Ringing In Your Ears	YES	NO
Tension Headaches	YES	NO
Teeth Grinding	YES	NO
Bad Reaction to Dentistry	YES	NO
Jaw Clicking or Popping	YES	NO
Lip Sucking or Biting	YES	NO
Nail Biting	YES	NO
Speech Problems	YES	NO

Have you ever seen an Orthodontist? If yes, when? _____

_____

Have you ever had orthodontic treatment?	YES	NO
Have you had your adenoids/tonsils removed?	YES	NO
Do have any missing/extra permanent teeth?	YES	NO
Do you brush your teeth daily?	YES	NO
Do you floss your teeth daily?	YES	NO

Additional Information

Please list any other concerns/issues that you would like to discuss with the doctor.

_____

_____

_____

_____

_____

By signing below, I am authorizing that I have answered all of the above questions accurately and to the best of my knowledge. If, at any time, there are any changes to the medical or dental history, I will inform Braces@Brick as soon as possible.

_____ _____

Signature of Responsible Party *Date*

FINANCIAL POLICY

We are committed to providing you with the best possible care. We would like our patients to be informed of our office financial policy. We base our fees on our quality, expertise, time, and service. We clearly list and explain all of our fees in our treatment consultation and provide you with a written estimate of what your financial obligation will be.

If you have orthodontic insurance, you must bring proof of insurance and we will be happy to prepare the necessary forms for this important benefit. If you were not issued a card, please provide us with the following information:

- Insurance carrier name and phone number
- Subscriber Name/DOB/SS#
- Subscriber ID Number and Group/Plan number

However, we remind you that your insurance is a contract between you, you employer and the insurance company, **not between your insurance company and our office**. We can make no guarantee of any estimated coverage, but we will do our best to see that you receive your maximum benefits. *Your bill is ultimately your responsibility should insurance not cover the expected amount due, or should your insurance fail to pay us.*

Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. Not all services are covered in all contracts and some companies arbitrarily select certain services they will not cover.

At times, certain services may fall under your medical insurance coverage. Due to variations of benefits, coverage for these services is not a guarantee. Our office requires payment for these services in full and will gladly submit these procedures to your medical insurance provider. Should payment be received from your insurance company, we will issue a reimbursement to you.

We offer convenient payment plans through our office as a courtesy to you. To make your payment, we accept all major credit cards, personal checks, and cash. In addition, we offer an excellent third party financial payment plan through CareCredit.

We encourage anyone having temporary financial problems to contact us immediately so that we may assist you in the management of your account. Any portion of a past due balance beyond 60 days may incur a monthly service charge. Returned checks will incur a handling fee of $35.00. Any account over 90 days past due will be subject to legal action.

Our primary concern is your complete oral health. Nonetheless, we will be sensitive to you financial circumstances within the framework of sound business practices.

_____ _____

Responsible Party Signature *Date*

APPOINTMENT POLICY

We are dedicated to quality care and scheduling appointments for you that are convenient and fit into your personal schedule. During orthodontic treatment, the patient is seen every few weeks and some of these appointments may conflict with work or school schedules. Afternoon and evening appointments book up several weeks in advance and we ask that you please schedule your appointment before leaving the office in order to receive your desired time.

The majority of your appointments can be scheduled at any time of day and are quick checks, observations, or minor adjustments to ensure the braces/appliances are working properly.

There are several appointments that require scheduling in the morning or during school/work hours. These appointments are as follows:

- Placement of the braces
- Removal of the braces
- Placement of certain appliances
- Emergency visits

There can be NO exceptions for these appointments since they often require an extended period of time with Dr. Young and the utmost attention to detail.

Occasionally, the patient may have a broken bracket or wire. If the patient is not in pain or discomfort, please call the office so we can add more time to the next appointment for the repair. However, if an "emergency" appointment is needed, we can schedule this repair in the morning or early afternoon (before 2:00pm). Should your personal schedule conflict with these emergency appointment times, we will be happy to provide you with our next available appointment.

Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. We will try to work you into our schedule if time allows but will ask you to reschedule if this is not possible. We respect our patients time and make every effort to remain on schedule. However, some visits are more complicated than initially anticipated, and emergencies may arise that could possibly delay us.

_____ _____

Responsible Party Signature *Date*

HIPAA Compliance Patient Consent Form

Name of Patient: _____ **Date of Birth:**_____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/ date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountable Act of 1996) law allows for the use of the information for treatment payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at anytime and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments and forward office information **Yes/ No**
May we leave a message on your answering machine at home or on your cell phone? **Yes/ No**
May we discuss your financial and medical condition with any member of your family? **Yes/ No**

If YES, please name the members allowed: _____

_____

I, _____(please print), have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. 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.

This consent was read and signed by: _____

Relationship to Patient: _____

Signature: _____ Date: _____

AUTHORIZATION AND RELEASE

SECTION A: RECORDS CONSENT

By initialing, I hereby consent to the taking of x-rays, photographs, and other necessary records for orthodontic treatment. I understand requests to **copy/transfer** these records to another office will incur a full records fee of $250.

_____
INITIAL

SECTION B: AUTHORIZATION AND RELEASE

I consent to the examination and treatment of the above stated patient. I understand that where appropriate, credit bureaus may be obtained to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of my signature on all my insurance submission whether manual or electronic.

_____
INITIAL

SECTION C: ELECTRONIC COMMUNICATIONS

I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications and I may opt-out at any time by clicking the unsubscribe link provided in the email, or by replying STOP to the texts.

_____
INITIAL

SECTION D: ATTESTATION

I certify that I have read and answered the above information to the best of my knowledge and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of these forms. If there are changes to the patient's medical or dental history, I will so inform the practice.

_____
INITIAL

_____
Print Name of Responsible Party

_____
Signature

_____
Date

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.