ORTHODONTIC PATIENT INFORMATION

Acct. No. ________________

Patient Name ________________ Home Phone ________________
Birth Date ________________ Age ______ Sex ______ Hobbies/Sports ________________
Home Address ________________ Referred by? ________________

FOLLOWING INFORMATION APPLIES TO PERSON RESPONSIBLE FOR PAYMENT:

Name ________________ Relationship ________________ Soc. Sec. No. ________________
Employed By ________________ Occupation ________________
Bus. Address ________________ Bus. Phone ________________
Dental Insurance ________________ Group No. ________________
Insurance Address ________________ Insurance Phone ________________
Name of Secondary Insurance (if applicable) ________________
Secondary Insurance Group No. ________________ Was Benefit Ever Used? . . . . ☐ Yes ☐ No

MEDICAL HISTORY

Please circle those conditions that pertain to the Patient:

Endocrine Problems	Rheumatic Fever	Aids	Tuberculosis	Fainting/Dizziness
Bone disorder	Heart Problems	Diabetes	Epilepsy	Asthma/Allergy
Prolonged Bleeding	Hepatitis	Anemia	Pneumonia	Allergy to Penicillin
Nervous Disorder	Liver Problems	Cancer	Kidney Problems	Allergy to certain drugs

Others not listed ________________ Family members with these symptoms ________________
Does patient often have: ____colds ____sore throat ____ear infection. Have tonsils been removed? ________ What age? ________
List medications and purpose of each ________________
Hospitalized recently? ☐ Yes ☐ No Reason ________________
Physician's Name ________________ City/State ________________ Phone No. ________________

Answer the following if patient is a minor:

Has patient reached puberty? (Boy has voice changed; Girl has menstruation begun) . . . . ☐ Yes ☐ No
Height ________ Weight ________ Breast Fed Only ☐ To what Age? ______ Breast Fed and Bottle Fed ☐ Bottle Fed Only ☐

DENTAL HISTORY

History of injury to face, mouth or teeth? . . . . ☐ Yes ☐ No
History of sucking thumb/finger or lip . . . . ☐ Yes ☐ No
Does patient snore when sleeping? . . . . ☐ Yes ☐ No
Difficulty in breathing through the nose? . . . . ☐ Yes ☐ No
Is Patient a mouth breather? . . . . ☐ Yes ☐ No
While awake? . . . . ☐ Yes ☐ No
While asleep? . . . . ☐ Yes ☐ No
Had either parent orthodontic treatment? ☐ Yes ☐ No
Frequent migraine headaches? ☐ Yes ☐ No Stuffiness or Ringing in the ear? ☐ Yes ☐ No Dizziness or Vertigo? ☐ Yes ☐ No
List any musical instruments played ________________
Has the patient had previous orthodontic consultation or treatment? ☐ Yes ☐ No With whom? ________________
Name of attending Dentist ________________ City/State ________________ Phone No. ________________
Please describe the problem you see and what you expect from treatment: ________________

____

OFFICE POLICY REGARDING PAYMENT OF FEES

Payment is expected for service rendered at the time of the first visit. Financial arrangements for subsequent treatment will be made following diagnosis and treatment plan presentation.

Patient's Signature (Parent's if Patient is a minor) ________________ Date ________

Thank You For Coming To Our Office

Yosh Jefferson, DMD© 1996 This chart is protected by copyright, reproduction is prohibited.

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2) Obtain payment from third-party payers (i.e., your dental and/or medical insurance).
3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have read your Notice of Privacy Practices posted in front of the reception desk containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____ Relation to Patient: ________________________

Signature (Head of Household): ____________________________________ Date:______________________

HIPAA PRIVACY FORM

ACKNOWLEDGEMENT OF RECEPT OF NOTICE OF PRIVACY PRACTICES
You, As the Patient, May Refuse to Sign This Acknowledgement

I have read a copy of this office's Notice of Privacy Practice. Copy is posted or upon request a copy handed to be read. As adult of the household, I am signing this acknowledgement for the entire household.

Name (Head of Household): ____

Signature (Head of Household): ____________________________________ Date:______________________

For Office Use Only

A staff member attempted to obtain the patient's signature in acknowledgement on this Notice Of Privacy Practices Acknowledgement but was unable to do so as documented below:

- ○ Communication barriers prohibited obtaining the acknowledgement.
- ○ An emergency situation prevented us from obtaining acknowledgement.
- ○ Other ____

FINANCIAL POLICY
Thank you for choosing us as your dental health care provider. We are committed to giving you exceptional dental treatment. The goal is not to allow the cost of treatment to prevent you from getting the quality care you need or desire. Our financial options are as follows and payment is due at time of service unless prior arrangements have been made:

1, Cash or Check ($40 returned check charge)
2, MasterCard, VISA, or Discover
3. Care Credit and Citi for patients desiring more than 90 days to pay for treatment
5% Discount for payment in full by cash prior to treatment for services exceeding $2,500.

Insurances
We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. If you are unable to present a valid member identification card from your insurance carrier at your initial visit, we will expect payment in full until you are able to verify your insurance coverage. Payment for dental services is the responsibility of the patient.

Balances
The office cannot carry balances longer than 60 days, even if insurance payments are still pending. If your insurance company does not pay within 60 days, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. If payment has not been received after 90 days, we will inform you of the delinquent account and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay any fees associated with the collection of the account.

Missed Appointments
An appointment is a dedicated time set aside for you. When an appointment is broken or cancelled on short notice (less than 48hrs) it prevents us from helping someone else. Please provide at least a 48 Hour notice to change your appointment. A $15/every 15 minute increment will be charged if you do not show up for your appointment unless a 48 hour notice is given.

Usual and Customary Rates
In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your estimated costs. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. The patient is ultimately responsible for payment regardless of the insurance company's determination of usual and customary rates.

Waiver of Confidentiality
The patient understands if the office submits your account to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit report agency, the fact that you received treatment at our office may become a matter of public record.

Divorce Situations
The parent who brings the minor and has signed the financial agreement is responsible to pay for the child’s services independent of what a divorce decree may state. We are unable to bill separate parties; therefore parents can work out these details.

Finance Charge
A 1.5% finance charge will be billed for balances over 60 days.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have.

By signing below, I agree and understand the Financial Policy.

Printed Name of Responsible Party ____

Name of Minor (if applicable)____

Signature of Patient or Responsible Party: ____

Date:____________________