WELCOME TO THE ORTHODONTIST

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____
(CHILD PREFERS TO BE CALLED)

Child's Name: _____
(LAST FIRST MI)

E-mail Address: _____ SS#: _____

Birthdate: ___/___/___ Age: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____
(APT/CONDO #)

_____
(CITY STATE ZIP)

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

List brothers / sisters with age: _____

_____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

3 ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____) _____ Hm #: (____) _____

Employer: _____ Wk #: (____) _____

SS #: _____ DL #: _____

☐ Father's Information: ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____) _____ Hm #: (____) _____

Employer: _____ Wk #: (____) _____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____
(CITY STATE ZIP)

Previous Address: _____

_____
(CITY STATE ZIP)

Hm # (____) _____ DL #: _____

Cell # (____) _____ SS #: _____

Employer: _____ Wk # (____) _____ Ext: _____

Who is responsible for making appointments?

Name: _____

Wk # (____) _____ Ext: _____ HM #: _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

CONTINUED ON BACK

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What are the main concerns that you would like orthodontics to accomplish? _____

_____

Has your child ever taken Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If yes, when? _____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

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

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: (____)_____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: _____

_____

Please list all drugs / things that your child is allergic to: _____

_____

Y N Latex Y N Metals/Nickel Y N Plastics

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Has your child ever had any of the following medical problems?

Y N	Abnormal Bleeding	Y N	Convulsions / Epilepsy
Y N	ADD / ADHD	Y N	Diabetes
Y N	Allergies to any Drugs	Y N	Handicaps / Disabilities
Y N	Allergic to Latex / Metals	Y N	Hearing Impairment
Y N	Allergic to Plastic	Y N	Heart Murmur
Y N	Any Hospital Stays	Y N	Hemophilia
Y N	Any Operations	Y N	Hepatitis
Y N	Artificial Bones / Joints / Valves	Y N	HIV+ / AIDS
		Y N	Kidney / Liver Problems
Y N	Asthma	Y N	Lupus
Y N	Cancer	Y N	Rheumatic / Scarlet Fever
Y N	Congenital Heart Defect	Y N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

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Has your child ever experienced any of the following?

Y N	Clenching / Grinding Teeth	Y N	Nursing Bottle Habits
Y N	Lip Sucking / Biting	Y N	Speech Problems
Y N	Mouth Breather	Y N	Thumb / Finger Sucking
Y N	Nail Biting	Y N	Tongue Thrust

Neighbor or Relative not living with you.
Name _____ **Phone** (___) _____
Address _____
_____
CITY STATE ZIP

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I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian **Date**

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
Signature of parent or guardian **Date**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of parent or guardian **Date**

The Parent or Guardian who accompanies the child is responsible for payment.
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.

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

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: Initials: _____ Date: _____

_____

_____

_____

Dental Associates, LLC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify)

_____

_____

_____

(PLEASE SEE BACK PAGE)

Carroll County Dental Specialists

I authorize Dental Associates, LLC to discuss personal treatment and finances with the following individual (s):

Name	Relationship
Name	Relationship
Patient Signature	Date

2029 Suffolk Road * Finksburg, MD 21048
410-861-3001 * fax: 410-861-8744

Dental Associates LLC
T/A: CARROLL COUNTY DENTAL SPECIALISTS
2029 Suffolk Rd, Suite B
Finksburg, MD, 21048
(410) 861-3001

To Our Private Insurance Patients

We will prepare an estimate for the treatment that is to be performed. Please understand that this is only an estimate and is based on the accuracy of the information available to us by the insurance provider. Any difference in the estimate and the actual payment from the insurance company will be the patient's responsibility.

It is important to familiarize yourself with your dental benefits, so you are aware of all deductibles, co pays, maximums, and time restraints associated with your policy.

We would like you to understand fully that the responsibility for payment is yours.

To Our HMO Patients

The patient is responsible for eligibility in their insurance program.

Due to greatly reduced fees, all patient co-payments are due in full at the time of service.

Please review your individual plan benefits so you are familiar with your financial responsibility for any services we might perform for you.

All Patients

Patients without insurance are responsible for their full balance at the time of service.

All new patients under the age of 18 must be accompanied by their parent or legal guardian, so that all forms are completed and signed.

We reserve the right to charge for broken or missed appointments without a 24-hour notice of cancellation. A fee of $15 per 15 minutes will be assessed for failure to give proper notice to the office. A **$37.00** service charge will be applied for all returned checks.

I understand that Dental Associates, LLC, reserves the right to pursue delinquent accounts via a third party collection agency or attorney. In the event Dental Associates, LLC, refers my bill for collection, I agree to pay, for collection and/or legal services, an additional thirty percent (30%) of the amount owed.

Patient's Name _____

X _____ **(SEAL)** _____

Signature of Patient/Guardian **Date**

Carroll County Dental Specialists
2029 Suffolk Road, Suite B
Finksburg, MD 21048
(410) 861-3001

Important Insurance Information

We offer a valuable service to our patients; we file your insurance claims and predetermination of service for you at no cost. We also accept assignment on many insurance plans. This means we bill the insurance company, they pay us directly their portion of the fee, and we only collect a co-payment from the patient at the time of service. However, what makes this service very difficult is the fact that there are over 23,000 different insurance plans in the United States. Since our primary purpose is providing the highest quality dental care and service to our patients, it is not possible for us to know all there is to know about these plans.

The insurance policy is a legal contract between the policyholder (you) and the insurance company. The insurance must answer to you, they must respond to your requests, and they will often pay you much more readily and quickly than they will a doctor's office. This is important for you to know, because YOU are responsible for your insurance, not us. A doctor has no legal power to force an insurance company to pay. But you as the policyholder have a great deal of legal power and rights regarding your insurance.

Most dental plans have limitations and restrictions. No insurance policy pays 100% of all dental fees. Dental insurance is not meant to pay everything, it is only meant to be a supplement. Also, even when a plan states that it covers a percentage of the fees – for example 80% - that is usually not entirely true. Most plans cover only 40-50% of the fees. The amount your plan pays is determined by how much your employer paid for the plan. We will help you determine the amount of coverage your plan offers for each service we provide for you.
Our policy is to help our patients as much as possible with any and all aspects of their dental care while here in our office. This includes insurance. We have developed financial policies over the years, which help us keep focused on our purpose – quality dental care and superior service. While we do everything we can to help out patients with their insurance companies, we sometimes need your help, because only you have the legal power to deal with your insurance company regarding certain issues.

We ask that you understand and agree to these policies, so we are able to serve you better. We don't want financial issues to come between you and the dental care you deserve.

(PLEASE SEE BACK OF PAGE)