WELCOME
TO THE ORTHODONTIST

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

E-Mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____ APT/CONDO #:

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Other #: _____

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

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

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

Birthdate: ___/___/___

Person Responsible for Account: _____

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

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones / Joints / Valves	Y	N	High / Low Blood Pressure
Y	N	Asthma / Arthritis	Y	N	HIV+ / AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for Any Reason
Y	N	Cancer / Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Severe / Frequent Headaches
Y	N	Epilepsy / Seizures / Fainting	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack / Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers / Colitis
Y	N	Heart Surgery / Pacemaker	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Any Metals/Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

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

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No Gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

I

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Thank you for filling out this form completely.

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 the office, use the services of one or more credit reporting services.

_____

Signature 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 (otherwise payable to me) directly to this office.

_____

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.

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 patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

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)