PATIENT INFORMATION

NAME: ____________ PREFERRED NAME: ____________

BIRTHDATE: ____________ AGE: ______ SSN: ____________ GENDER: ☐ MALE ☐ FEMALE

ADDRESS: ____________ CITY: ____________ ZIP: ____________

CELL PHONE: ____________ EMAIL: ____________

SCHOOL: ____________ GRADE: ____________

DENTIST: ____________ DATE OF LAST VISIT: ____________

SIBLINGS: (Name & DOB) ____________

HAS THE PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? ☐ YES ☐ NO IF SO, WHERE? ____________

PARENT/GUARDIAN INFORMATION

NAME: ____________ EMAIL: ____________

HOME ADDRESS: ____________ # OF YEARS @ ADDRESS: ____________

PHONE: (cell) ____________ (work) ____________ (home) ____________

EMPLOYER: ____________ # OF YEARS: ______ OCCUPATION: ____________

BIRTHDATE: ____________ SSN: ____________

INSURANCE INFORMATION

INSURED NAME: ____________ BIRTHDATE: ____________ SSN: ____________

INSURED ADDRESS: ____________

EMPLOYER: ____________ INSURANCE COMPANY: ____________

INS. ID#: ____________ GROUP#: ____________ INS. PHONE#: ____________

CLAIMS ADDRESS: ____________

EMERGENCY CONTACT

NAME: ____________ RELATIONSHIP TO PATIENT: ____________

CONTACT PHONE NUMBER: ____________ EMAIL: ____________

ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? ____________

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

Retention of Documents Relating to Patient Care. By signing this, you understand and agree that it is our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME ____________ **SIGNATURE** ____________ **DATE** ____________

DENTAL HISTORY

CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:

- ☐ Blisters on lips/mouth
- ☐ Broken fillings
- ☐ Burning sensation, tongue
- ☐ Chews on tongue
- ☐ Dry mouth
- ☐ Extracted teeth
- ☐ Finger/thumb habits
- ☐ Food trapped between teeth
- ☐ Grinding teeth
- ☐ Gums bleeding
- ☐ Gums sore/swollen
- ☐ Injuries to teeth/jaw
- ☐ Injuries to face/head
- ☐ Jaw clicking/popping
- ☐ Jaw locking open/closed
- ☐ Jaw pain/tenderness
- ☐ Jaw surgery
- ☐ Lip/cheek biting
- ☐ Loose teeth (other than baby teeth)
- ☐ Mouth breathing
- ☐ Mouth pain when brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Periodontal surgery
- ☐ Sensitivity to hot or cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity to pressure
- ☐ Sores/growths in mouth
- ☐ Speech problems
- ☐ Tongue thrust

HOW OFTEN DOES THE PATIENT BRUSH? ______________________ FLOSS? ______________________

ADDITIONAL COMMENTS: ____

MEDICAL HISTORY

CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:

- ☐ AIDS
- ☐ Anem
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood diseases
- ☐ Bone disorders
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatment
- ☐ Coughing - persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV Positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous system problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Stomach ulcers
- ☐ Swelling of feet
- ☐ Thyroid problems
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tonsils removed
- ☐ Tuberculosis
- ☐ Urinary problems

☐ Other (not listed) ______________________

FEMALES ONLY IS IT POSSIBLE THE PATIENT IS PREGNANT? ☐ YES ☐ NO

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

FOR WHAT CONDITION? ____

PHYSICIAN'S NAME: ______________________________ PHONE #: ______________________

MEDICATIONS:
Please list **ANY & ALL** medications the patient is currently taking:

____

____

____

ALLERGIES:
Please list **ANY & ALL** known allergies you are aware of (EXAMPLE(S): Latex, Metal, Medications):

____

IS THE PATIENT CURRENTLY TAKING OR HAS TAKEN ANY BONE DENSITY MEDICATIONS? ☐ YES ☐ NO
(Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

The above information is accurate and complete to the best of my knowledge and is only for use in my child's treatment. It is my responsibility to inform this office of any changes in my child's personal information or health status. I will not hold this office, our doctors or our staff responsible for any errors or omissions that I have made in the completion of this form.

NAME ______________________ **SIGNATURE** ______________________ **DATE** ______________________

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form. Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent. Thank you for your cooperation. Please let us know if you have any questions.

Signature:____ **Date**: _________________________

PATIENT PHOTO RELEASE

Patient Name: ____

PATIENT PHOTO RELEASE

Patient Name: ____

The above named patient (or parent/legal guardian) of Boerne Orthodontics & Pediatric Dentistry, consents to: (i) have the patient's likeness and/or voice recorded on a video, audio, photographic, digital, electronic or any other medium; (ii) the use of their name in connection with such recordings; and (iii) the use, reproduction, exhibition, and/or distribution of their name and such recordings in any medium (e.g. print publications, video, internet, etc.) for promotional, advertising, education, and/or other lawful purposes. The patient (or parent/guardian) releases and waives any claims or rights of ownership or compensation regarding such uses and understands that all such recordings shall remain the property of Boerne Orthodontics & Pediatric Dentistry.

❏ I authorize the recording and use of photo/videos as outlined above

❏ I DO NOT authorize the recording and use of photos/videos as outlined above

Signature: ____ **Date:** _________________________

AUTHORIZE
CHANGE OF TREATMENT

Patient: ____ Date: ___________________

Patient DOB: ___________________ Phone #: ____________________________

I __________________________ the parent /guardian of ___________________________, authorize
Name / Legal Guardian Patients Name

the following ___________________________, to bring my child/children to any future dental
Person/People

appointments. As well as making any necessary decisions regarding my child's dental treatment. This may include the use of a papoose blanket or any other treatment deem necessary in the best interest of the child. I fully understand these changes may include adjustments to the treatment plan which may have an effect on additional costs that will be required to be paid in full of the day of service as discussed when the initial treatment plan was presented and signed on Date ____________.

By signing below all parties listed are aware of the possibility of having the authority to make a decision to change treatment and pay additional cost. We invite your questions concerning the possibility of change in treatment. By signing below you acknowledge that you have read this document, understand the information presented, and we have had all your questions answered satisfactorily.

Name	Relation to Patient	Phone Number
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Parent/Guardian:_____________________________________ Date:________________

FINANCIAL AGREEMENT

Thank you for selecting us as your personal dental and orthodontic care team. To promote a long-term, mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. Please read this carefully and ask any questions or bring up concerns before treatment is rendered.

Treatment:
We will always recommend treatment based on optimal care, and not on insurance benefits. We will, however, always offer alternate treatment options that may better fit your health care budget.

Insurance:
As a courtesy to you, we will submit all insurance claims on your behalf, and any follow-up processes that may be necessary. Our staff prides itself on helping our patients maximize their benefits, and are always available for questions. Ultimately, **the patient is fully responsible for the charges for the treatment rendered.** Your **Insurance may not cover** the services or may only **partially** cover them and any **estimate** given by this office is considered a guideline until insurance payment is received and the patient's account is reconciled. The office makes no guarantee of the actual payment by your insurance company. At no time will we change treatment codes or dates of service to manipulate your insurance benefits. This is insurance fraud.

Missed Appointments:
When we schedule your appointment, this time is reserved exclusively for you. When you fail to notify us of your inability to keep the appointment, another patient in need of care is unable to receive treatment. We request that you give us one business day's notice when you realize you cannot keep an appointment. A fee of $50.00 per hour scheduled may be charged for a broken appointment.

Payment at time of service:
We accept cash, personal checks, MasterCard, Visa, Discover, American Express, and HSA/FSA cards. In addition, we offer Care Credit and Lending Point for those requiring extended payment plans. We will collect any deductible or estimated copay at time of service.

I understand that I am responsible for all fees incurred for dental treatment and agree to pay according to the option I have chosen. Additional charges may occur if the account is turned over for collection.

Signature (parent/legal guardian if minor): ____ Date: _____________

Patient's name: ______________________________ Guardian's name: ____________________________