Boerne ORTHODONTICS & PEDIATRIC DENTISTRY

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** _____

PATIENT NAME: _____

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
- ☐ Autism
- ☐ 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** _____

HIPAA FORM

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

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certification.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 above 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 of health care operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

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.

May we phone/text/email you regarding your appointment?	**YES**	**NO**
May we send e statements in regards to your account?	**YES**	**NO**
May we leave a message on your answering machine or voicemail?	**YES**	**NO**
May we discuss your medical condition with any member of your family?	**YES**	**NO**

If **YES**, please name the members allowed:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HIPAA Privacy

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

_____ _____

Signature Date

AUTHORIZE
CHANGE OF TREATMENT

Boerne ORTHODONTICS & PEDIATRIC DENTISTRY

Patient: _____ Date: _____

Patient DOB: _____ Phone #: _____

I _____ the parent /guardian of _____, authorize
Name / Legal Guardian Patient's 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 _____

NOTICE OF FILMING AND PHOTOGRAPHY

Patient Name: _____

When you enter Full Smile Dental you are entering an area where photography, audio, and video recording may occur.

By entering the premises, you consent to interview(s), photography, audio recording, video recording and its/their release, publication, exhibition, or reproduction to be used for news, webcasts, promotional purposes, telecasts, advertising, inclusion on websites, social media, or any other purpose by Full Smile Dental and its affiliates and representatives. Images, photos and/or videos may be used to promote similar Full Smile Dental events in the future, highlight the event and exhibit the capabilities of Full Smile Dental. You release Full Smile Dental, its officers and employees, and each and all persons involved from any liability connected with the taking, recording, digitizing, or publication and use of interviews, photographs, computer images, video and/or sound recordings.

By entering the Full Smile Dental premises, you waive all rights you may have to any claims for payment or royalties in connection with any use, exhibition, streaming, webcasting, televising, or other publication of these materials, regardless of the purpose or sponsoring of such use, exhibiting, broadcasting, webcasting, or other publication irrespective of whether a fee for admission or sponsorship is charged.

You also waive any right to inspect or approve any photo, video, or audio recording taken by Full Smile Dental or the person or entity designated to do so by Full Smile Dental. You have been fully informed of your consent, waiver of liability, and release before entering the premises.

Signature: _____ Date: _____

(parent or guardian if minor)

Signature: _____ Date: _____