BRUSHANDFLOSS ORTHODONTICS

ADULT

Welcome to our Practice

Thank you for choosing our office for your dental care.
We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. Please familiarize yourself with the policies of this office. This form must be read and signed before treatment is rendered. **Please ask questions if you do not understand any of these policies.**

Financial Agreement

- I understand that payment for services is completely my responsibility.
- I understand that my insurance is an agreement between the insurance company and me and not between BrushAndFloss Orthodontics and the insurance company. (Insurance is filed as a courtesy)
- For the office to accept insurance as payment I must provide current dental insurance information and/or insurance card. I understand I am responsible for remitting payment of the patient portion of the insurance.
- I understand that if insurance cannot be verified or if I do not have insurance, I will be responsible for full payment.
- I understand that any payment arrangements, when applicable, are to be made upon signing of contract or at the time of service.
- I understand that I will be charged a $25 late fee for any payments over 30 days.
- I understand that if for any reason my account is turned over to a collection agency, I will be responsible for any and all fees to collect my balance.

Appointments

In order to provide quality, effective care, we utilize an appointment schedule. Our office hours are Monday through Thursday 8 am to 5 pm, and Friday 8 am to 2 pm. (closed for lunch 1-2 pm). We aim to give you all the time and attention your dental care requires while you are in our office. However, if you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment. We are available when emergencies arise, and will do our best to give prompt consideration as needed.

Cancellation Policy

To cancel your appointment, please notify our office at least twenty-four (24) hours in advance of your scheduled appointment time. Appointment changes can only be accepted during regular office hours. You may be charged a fee for not providing a twenty-four (24) hour notice of cancellation or failing to show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than $50.00. Two (2) missed appointments may lead to an inability to schedule you for future appointments. Parents may accompany children in the operatories by invitation only. However, we do require that you remain in the building with minor children (under 18 years of age) for the entire appointment. We provide children with the same care that our adult patients receive and prefer to care for them as individuals.

Medicaid Patients

If you have Medicaid insurance, you must have your card, picture ID, and your $3.00 co-pay as required. If you do not have all of these requirements we will have to reschedule your appointment.

YOUR SIGNATURE BELOW CERTIFIES YOU HAVE READ, UNDERSTAND AND AGREE TO THE FINANCIAL AND OFFICE POLICY PROVISIONS STATED ABOVE.

Patient Name (Please Print)	Patient | Parent or Guardian Signature	Date

BRUSHANDFLOSS ORTHODONTICS

ADULT

Patient Information

Please complete in ink (Required*)

*Full Name_____*Date of Birth_____

*Email Address_____

*Address_____*City_____*State____*Zip Code_____

*Telephone: Home_____*Work_____ *Mobile_____

*Social Security #_____*Driver's License#_____

Occupation_____Employer_____

Gender_____Age_____Height_____Weight_____

*Emergency contact name: _____*Phone:_____

Preferred method of billing ☐ **By Mail** ☐ **Online Billing (using email address above)**

*GUARDIAN OR RESPONSIBLE PARTY

Full Name_____Relationship_____

Address_____ _____

Home Phone_____*Work_____*Mobile_____

*INSURANCE POLICY

Name of Insured_____

Date of Birth_____ Social Security_____

Employer_____ Insurance Company_____

Address_____

Policy#_____Group#_____Phone#_____

Do you have additional dental insurance? Yes No If yes, please notify our staff.

We are happy to assist you in understanding and filing your insurance for most dental procedures. Please remember your insurance is a contract between you, your employer, and your insurance company. Please understand that we cannot speak on their behalf. We will gladly act as an advocate but cannot be responsible for settling any disputed claims or coverage. We require payment of patient's estimated portion at the time of treatment. Our office policy states that you are solely responsible for your bill. Failure of your insurance carrier to reimburse our office will result in our billing you directly for the remaining balance.

_____ _____ _____

Patient Name (Please Print) Patient |Parent or Guardian Signature Date

BRUSHANDFLOSS ORTHODONTICS

ADULT

All information provided here is kept completely confidential, thus any attempt to conceal pre-existing conditions or other relevant information could result in serious patient – drug interactions or death. The following questions must be answered honestly so our office can provide you with the best possible care and service. If we determine that questions have not been answered honestly, you will be dismissed from our practice.

- Physician's name_____ _____phone number_____

Address_____

Last seen_____ Reason _____ Next appointment_____

- Other physicians/health care providers being seen now:

Name_____ Phone number_____
Reason_____
Name_____ Phone number_____
Reason_____

- Name of current/previous dentist _____phone number_____

Address_____ _____

Last seen_____ Reason _____ Next appointment_____

General Information

What concerns YOU about YOUR teeth?_____

Who suggested that you might need orthodontic treatment?_____

Why did you select our office?_____

Have you had any previous orthodontic treatment? Please describe_____

Have you ever had an orthodontic consultation before now?_____

Have any other family members been treated in this office? Please name them_____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain._____

_____

Have you noticed any changes in your face or jaws?_____

Any other physical problems?_____

_____	_____	_____
Patient Name (Please Print)	Patient |Parent or Guardian Signature	Date

BRUSHANDFLOSS ORTHODONTICS

ADULT

Medical History

- Please list all medication(s) (Prescription or Over-the-Counter) that you take:

_____

_____

- Do you usually take medication before dental treatment? If so, what medication and why?_____

_____

- Have you ever taken any medications to strengthen your bones? Please describe._____

_____

- Are you allergic to, or have you had unusual reactions to any of the following? If Yes, circle all that apply:
  Local anesthetics - Latex – Aspirin - Metals – Penicillin – Other antibiotics – Ibuprofen - Acrylics

Other_____What happens?_____

Now or in the past, have you had:

Condition:	Yes	No	Condition	Yes	No
Abnormal Bleeding/Bruising/Anemia			Hepatitis, jaundice, or other liver problems		
AIDS/HIV			High or Low Blood Pressure		
Angina, arteriosclerosis, stroke or heart attack			History of eating disorder		
Any injuries to face, head, neck?			History of Osteoporosis		
Arthritis or joint problems			Hormone/Endocrine Disorders		
Asthma, sinus problems, or hayfever			Illicit drugs, marijuana, cocaine		
Birth defects or hereditary problems			Immune system disorder		
Blood Disorders, Sickle Cell or Hemophilia			Kidney problems		
Bone fractures or major injuries			Liver Disease		
Cancer, tumor, radiation treatment			Mental health disturbance or depression		
Chest pain, shortness of breath, tire easily, swollen ankles			Mouth breathing or snoring		
Diabetes or low blood sugar			Polio, mononucleosis, tuberculosis, pneumonia		
Ear infections, colds, throat infections			Smoke or chew tobacco		
Endocrine or thyroid problems			Substance abuse		
Fainting or dizziness			Seizures, Epilepsy, or other neurologic problems		
GERD, Acid Reflux, or Stomach ulcer			Skin disorder other than common acne		
Gonorrhea, syphilis, herpes, sexually transmitted diseases			Tonsil or adenoid condition		
Headaches or migraines			Vision, hearing, or speech problems		
Heart defects, Heart murmur or rheumatic heart disease			Well-balanced diet		

Please list and describe any other disease(s), condition(s), or problems not listed above:

_____

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BRUSHANDFLOSS ORTHODONTICS

ADULT

FOR WOMEN ONLY:	Yes	No
Are you pregnant or suspect that you may be pregnant? If yes, How many weeks: _____		
Are you trying to get pregnant?		

Family Medical History:

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders_____ Diabetes_____

Arthritis_____ Severe allergies_____

Unusual dental problems_____ Jaw size imbalance_____

Other family medical conditions?_____

Dental History	Yes	No	DK/U		Yes	No	DK/U
Permanent or extra (supernumerary) teeth removed?				Tooth grinding or clenching?			
Supernumerary (extra) or congenitally missing teeth?				Clicking, locking in jaw joints?			
Chipped or injured primary or permanent teeth?				Have you been treated for "TMJ" or "TMD" problems?			
Any sensitive or sore teeth?				Soreness in jaw muscles or face muscles?			
Any serious trouble associated with previous dental treatment?				Bleeding gums, bad taste or mouth odor?			
Any lost or broken fillings?				Have you ever been diagnosed with gum disease or pyorrhea?			
Jaw fractures, cysts, infections?				Do your gums bleed when you brush or floss?			
Any teeth treated with root canals or pulpotomies?				Have you ever had periodontal (gum treatment)?			
"Gum boils," Frequent canker sores or cold sores?				Do you drink fluoridated water?			
History of speech problems or speech therapy?				Do you take any fluoride supplements?			
Difficulty breathing through nose?				Do you use fluoridated toothpaste?			
Mouth breathing habit or snoring at night?				How often do you brush? (circle your closest frequency) 1x's, 2x's, 3x's /day			
Frequent oral habits (sucking finger, chewing pen, etc)?				Do you floss regularly? (circle your closest frequency) Daily 2-4x/wk 1x/wk Periodically			
Teeth causing irritation to lip, cheek or gums?				Does you have any finger/thumb/ or other oral habits?			

	Yes	No
May we take dental x-rays on you if they are needed?		
I consent to the diagnostic procedure and treatment by the dentist necessary for proper dental care.		

Patient Name (Please Print) _____ Patient |Parent or Guardian Signature _____ Date _____

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ORTHODONTICS
ADULT

Please help us know how you found us by circling one of the following:

Insurance Provider	Radio	Groupon	Vendor Expo
Online Search	Facebook/Twitter	Angie's List	Other_____
Personal Referral	Drive By/Walk-in	Coupon	

Patient Name (Please Print)

Patient |Parent or Guardian Signature

Date

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ADULT

PRIMARY AND SECONDARY INSURANCE POLICY

BrushAndFloss Orthodontics provides the courtesy to our patients of filing both primary and secondary insurance.

However, both ADA policy and state COB laws provide that when an insurance company accepts premiums from an employer and the secondary carrier, it should coordinate benefits with the primary carrier and pay its appropriate amount as follows:

1. The coverage from those plans should be coordinated such that the patient receives the maximum allowable benefit from each plan;

2. The aggregate benefit should be more than that offered by any of the plans individually, but not such that the patient receives more that the total charges for the dental services received.

Therefore, if there is overpayment on your claim from your secondary insurance, the additional funds will be returned to your secondary insurance company, and will not be refunded to the patient. This is required by the National Association of Dental Plans (NADP), and American Dental Association (ADA).

Determining Primary and Secondary Insurance for the Patient.

The plan covering the patient, other than as a dependent, is the primary plan. When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary. When a determination cannot be made in accordance with the above, the plan that has covered the patient for a longer time should be considered as primary. BrushAndFloss Orthodontics provides this information to help patients understand primary and secondary dental policy. Should you have additional questions we recommend for you to contact your dental insurance provider or review the American Dental Association website at www.ada.org.

By signing below, I understand that BrushAndFloss Orthodontics follows ADA and state guidelines for primary and secondary insurance policies.

Patient Name (Please Print)	Patient |Parent or Guardian Signature	Date

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ORTHODONTICS
ADULT

HIPAA ACKNOWLEDGMENT

I _____ (printed name) acknowledge I have been provided a reference copy of the HIPAA Notice of Privacy Policy and may request a copy of said policy.

Furthermore, I understand my personal health, insurance or other personal information collected by BrushAndFloss Orthodontic will only be used as described in the aforementioned Notice of Privacy policy.

My signature at the bottom of this page indicates I have received, read, and understand that BrushAndFloss Orthodontic has communicated, to me, my rights under HIPAA.

Patient Name (Please Print)	Patient |Parent or Guardian Signature	Date