BRUSHANDFLOSS ORTHODONTICS

Adolescent

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 (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 are welcome to accompany children into the operatory. However, we do require that you remain in the building with minor children (under 18 years of age) for the entire appointment.

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 or Guardian Signature	Date

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Patient Information Please complete in ink (Required*)

*Child's Name_____*Date of Birth___/___/___ *Gender_____

Who has legal custody of the child? _____ Relationship: _____

*Address_____*City_____*State____*Zip Code_____

*Mothers Name_____ Email: _____

*Address_____*City_____*State____*Zip Code_____

*Phone: Home _____ Work_____ Mobile_____

*Fathers Name_____ Email: _____

*Address_____*City_____*State____*Zip Code_____

*Phone: Home _____ Work_____ Mobile_____

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 or Guardian Signature Date

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The following questions must be answered honestly so our office can provide your child with the best possible care and service. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in the current status as they occur.

Please provide your Pediatrician's name and phone number.

_____

Please list all medication(s) (Prescription or Over-the-Counter) that your child takes:

_____

Does your child take medication before dental treatment? If so, what medication and why?_____

_____

Does your child have any allergies? If so, to what?_____

What happens?_____

Date of your child's last dental visit _____Name of current/previous dentist _____

Address_____ Phone number_____

Please indicate your response by placing a checkmark in the appropriate column.	Yes	No
Is your child in good health today?		
When was your child's last medical exam?		
Has your child ever been seriously ill? If yes, please explain.		
Has your child ever been hospitalized? If yes, please explain.		
Has your child had any surgeries or operations? If yes, please explain.		
Is your child allergic to or had any unusual reactions to any of the following: (please circle any that apply) Latex Penicillin Red Dye Sulfa Drugs Metals		
Does your child chew or smoke tobacco?		
Does your child have (or ever had) a substance abuse problem?		

Patient Name (Please Print) Patient or Guardian Signature Date

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New PT HX FORM

What concerns you about child's teeth?_____
What concerns your child about his/her teeth?_____

Who suggested that you (or your child) might need orthodontic treatment?_____
Why did you select our office?_____

How does your child feel about orthodontic treatment?_____
Does patient have any history of orthodontic treatment? If yes, how long ago:_____
Does patient have any history of trauma to the face, mouth, or teeth? If yes, please provide details:
_____
Does patient have any family history of jaw or teeth problems? If yes, please explain:_____
_____

Brother/sister name_____ age___ had orthodontic treatment? Y__ N__ If yes, where?____
Brother/sister name_____ age___ had orthodontic treatment? Y__ N__ If yes, where?____
Brother/sister name_____ age___ had orthodontic treatment? Y__ N__ If yes, where?____
Brother/sister name_____ age___ had orthodontic treatment? Y__ N__ If yes, where?____

Does your child play an instrument?_____
Do you think that any of your child's activities affects his/her face, teeth, or jaws? How?_____
_____
Have you noticed any unusual changes in your child's face or jaws?_____
Does the patient exhibit any oral habits? If yes, please explain:_____

Does the patient have an emotional problem?_____
Is the patient learning disabled?_____
Any other physical problems?_____

Has patient experienced growth spurt within the last year?_____
Is continued growth expected?_____

Patient Name (Please Print)	Patient or Guardian Signature	Date

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Have your child ever had or have you been told that any of the following pertain to your child:

Condition:	Yes	No	Condition	Yes	No
Abnormal Bleeding/Bruising			Headaches		
ADD or ADHD			Hearing Impairment		
AIDS/HIV			Heart Complications Heart Murmur or Congenital Defect		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Asthma			Hormone/Endocrine Disorders		
Autoimmune disorder			Kidney Disease		
History of Child Abuse			Liver Disease		
Blood Disorders Sickle Cell or Hemophilia			Mental Health Care		
Cancer			Mental Delay		
Celiac Disease			Physical Delay		
Cerebral Palsy			Rheumatic Fever		
Cleft lip/Palate			Seizures/Epilepsy		
Congenital Birth Defects			Snoring		
Diabetes			Speech Delay		
Dizziness			Spina Bifida		
Frequent Infections			Stroke		
Gastrointestinal Disease			Tuberculosis		
GERD or Acid Reflux			Vision Impairment		

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

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?_____

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

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Dental History	Yes	No	DK/U
Erupting teeth very early or very late?			
Primary (baby) teeth removed that were not loose?			
Permanent or extra (supernumerary) teeth removed?			
Supernumerary (extra) or congenitally missing teeth?			
Chipped or injured primary or permanent teeth?			
Any sensitive or sore teeth?			
Any lost or broken fillings?			
Jaw fractures, cysts, infections?			
Any teeth treated with root canals or pulpotomies?			
Frequent canker sores or cold sores?			
History of speech problems or speech therapy?			
Difficulty breathing through nose?			
Mouth breathing habit or snoring at night?			
Frequent oral habits (sucking finger, chewing pen, etc)?			
Teeth causing irritation to lip, cheek or gums?			
Tooth grinding or clenching?			
Clicking, locking in jaw joints?			
Soreness in jaw muscles or face muscles?			
Has your child been treated for “TMJ” or “TMD” problems?			
Any broken or missing fillings?			
Any serious trouble associated with previous dental treatment?			
Has your child ever been diagnosed with gum disease or pyorrhea?			
Is your child drinking fluoridated water?			
Does your child take any fluoride supplements?			
Does your child use fluoridated toothpaste? If yes, how often?			
Does your child floss? If yes, how often?			
Does your child have any finger/thumb/pacifier habits or other habits (such a sucking on a blanket)?			

I consent to the diagnostic procedure and treatment by the dentist necessary for proper dental care.		

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

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

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

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

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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 or Guardian Signature	Date

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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 Orthodontics 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 Orthodontics has communicated, to me, my rights under HIPAA.

Patient Name (Please Print)	Patient or Guardian Signature	Date