

WELCOME



We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Troy Christensen, DDS, MS
Specialist in Orthodontics

Patient Information - Adult

Patient's Name _____ Age _____ Birth Date _____
First Middle Last

Nickname (if preferred) _____ Male Female

Home Phone _____ Cell Phone _____ SS # _____

Home Address _____ City, State, ZIP _____
Street

Employer _____ Employer's Address _____

Occupation _____ How Long? _____

General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? YES NO If YES, Name _____
First Middle Last

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

Have you visited an orthodontist before? YES NO If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? YES NO

Insurance Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Primary

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____

Secondary

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____

Dental and Medical History

Are you currently under the care of a physician? YES NO If YES, for what reason? _____

Physician _____ Phone # _____

History of major illness? YES NO If YES, please describe _____

Any sensitivities or allergies? YES NO If YES, please list _____

Currently taking any medications? YES NO If YES, please list _____ Amount/Dose _____

Have you been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	High Blood Pressure

Do you require antibiotics before dental treatment? YES NO If YES, explain _____

Have there been injuries to your face, mouth or chin? YES NO

Have you ever had pain/tenderness in your jaw joint (TMJ/TMD) YES NO

Do/Did you have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Tongue Thrusting
Chronic Mouth Breathing	Speech Problems	Chewing/Eating Problems

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits.

Signature _____ Date _____



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PAYMENTS

Please initial each line

- _____ The first payment is \$325. You are expected to make your first payment on the day braces are placed.
- _____ All monthly payments, whether personal check, automatic draft from your bank account or paid by credit card are due on either the 1st or 15th of the month.
- _____ A \$25.00 charge will be assessed for all returned checks. Once a check has been returned as NSF, we will only accept cash, money order or credit cards for payment.
- _____ Once an account is 60 days past due, the patient will be dismissed from the practice, unless written financial arrangements have been made prior to the 60 day past due status. If a patient is dismissed from the practice; our office will see the patient for emergencies only, for a period of 30 days.
- _____ The responsible party will pay any cost associated with collection of your account.

OFFICE POLICIES AND PROCEDURES

- _____ Intervals between appointments vary, depending on the treatment, on an individual case-by-case basis. Your/your child's appointments could be anywhere from 2 to 12 weeks apart.
- _____ 48 hour notice is required to cancel or reschedule appointments.
- _____ There will be an additional charge for any treatment performed by another doctor in conjunction with orthodontics; i.e., extractions, TMJ treatment, periodontal treatment, oral surgery treatments, dental treatments, etc. These charges are separate from and in addition to our orthodontic treatment.
- _____ There is a \$35.00 charge for missed appointments. Missed appointments can result in prolonged treatment and additional charges. 24 hour notice is sufficient to cancel the appointment without penalty fees
- _____ Lack of cooperation by the patient (poor brushing/flossing, not wearing appliances or rubber bands exactly as instructed, missed appointments, excessive appliance breakage, etc.) could result in prolonged treatment, a compromised treatment result, permanent damage to your teeth and additional charges. Consistent, poor cooperation will result in the braces being removed before completion of treatment and discontinuation of treatment.
- _____ The patient/parent is responsible for maintaining good cooperation and a consistent appointment schedule.
- _____ If a patient has an unscheduled absence from the practice for a period of 100 days, they will be automatically dismissed from the practice.
- _____ A dental cleaning and exam, along with necessary fillings, must be completed before appliances are placed. It is also your responsibility to keep regular 3-6 month dental cleaning and check-up appointments with your dentist.
- _____ All patients are advised to have a periodontal (gum tissue and supporting bone) exam by your general dentist, or in some cases a periodontist, before the initiation of orthodontic treatment. In some instances, you may be required to have an examination by a periodontist before initiating orthodontic treatment.
- _____ Progress reports and / or verbal communications are given at each appointment.
- _____ All regular appointments that are 40 minutes or longer will be scheduled before 3:00 pm. After school appointments must be alternated with school-time appointments. The patient's schedule will be accommodated if at all possible.
- _____ Our office strictly adheres to all state and federal OSHA regulations.

Patient / Parent / Legal Guardian

Orthodontist / Treatment Coordinator

Date

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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 below 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 or health care operation. I also understand you are not required to agree to my requested restrictions, 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.

Patient name: _____

Signature: _____

Relationship to patient: _____

Date: _____

NOTICE OF PRIVACY PRACTICES (DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health-care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.