WELCOME

We would like to welcome you and your child 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 - Child or Teen

Patient's Name ______________________ (First / Middle / Last) Age ______ Birth Date ____________

Nickname (if preferred) ______________ Male Female Patient's Home Phone ____________

Patient's Home Address ______________ (Street) City, State, ZIP ____________

Who is filling in this form? Name ______________________ (First / Middle / Last)

Relationship ______________ Do you have legal custody? YES NO

Patient's 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? ____________

Has your child visited an orthodontist before? YES NO If YES, for what reason? ____________

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

Parents Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Father

Father Step Father Guardian Name ______________________ (First / Middle / Last)

Address (if different than child's) ______________________ Birthdate ________

Home Phone ________ Work Phone ________ Cell Phone ________ SS # ________

Employer ________ Employer's Address ______________ Employer's # ________

If you have insurance coverage for the child, please fill out.

Insurance Company Name ______________ Group or plan # ________

Insurance Company Phone # ________ Insurance Company Address ______________

Mother

Mother Step Mother Guardian Name ______________________ (First / Middle / Last)

Address (if different than child's) ______________________ Birthdate ________

Home Phone ________ Work Phone ________ Cell Phone ________ SS # ________

Employer ________ Employer's Address ______________ Employer's # ________

If you have insurance coverage for the child, please fill out.

Insurance Company Name ______________ Group or plan # ________

Insurance Company Phone # ________ Insurance Company Address ______________

Dental and Medical History

Is the child currently under the care of a physician? YES NO If YES, for what reason? ____________

Child's 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 ____________

Has Puberty Begun? YES NO

Has menstruation (period) begun? YES NO NOT APPLICABLE

Has the child been treated for any of the following?

Arthritis Blood Disorder Diabetes Heart Condition Tuberculosis

Asthma Cancer Epilepsy Nervous Disorder

Does the child require antibiotics before dental treatment? YES NO If YES, explain ____________

Have the adenoids or tonsils been removed? YES NO

Have you been informed of any missing or extra permanent teeth? YES NO

Have there been injuries to the child's face, mouth or chin? YES NO

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD) YES NO

Does/Did the child have any of the following habits?

Grinding Teeth Finger/Thumb Sucking Prolonged Bottle/Pacifier

Mouth Breather 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 to this office.

Signature ____________ Date ____________

Christensen Orthodontics

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OFFICE POLICIES

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

530 N. Estrella Parkway, Suites C2 & C3 ❖ Goodyear, AZ 85338 ❖ Office (623) 925-8300 Fax (623) 925-0373

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PATIENT CONSENT

Member
American Association
of Orthodontists

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: ______________________

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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 alterative 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.