GENERAL PATIENT INFORMATION

DATE: _____

FIRST _____ MIDDLE _____ LAST _____ GENDER: M / F

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

EMAIL (For Appointment Reminders): _____AGE:_____BIRTHDATE: ____/____/____

HOME PHONE: ( )_____WORK PHONE: ( )_____ CELL PHONE: ( )_____

RESPONSIBLE PARTY:_____RELATIONSHIP TO PATIENT:_____

RESP. PARTY SOCIAL SECURITY #:_____RESPONSIBLE PARTY DOB:_____

ADDRESS FOR STATEMENTS (if different from above):_____

CITY:_____STATE:_____ZIP:_____

HAS ANY FAMILY MEMBER BEEN A PATIENT HERE? YES NO NAME: _____

HAS ANY FAMILY MEMBER WORN BRACES BEFORE? YES NO WHO WAS THE ORTHODONTIST?_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____PHONE: ( )_____

ADDRESS:_____CITY: _____STATE:_____ZIP:_____

WHEN WAS THE LAST TIME YOU VISITED A DENTIST OFFICE?_____DENTIST: _____ Phone: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? Name:_____

HOW MANY WAYS HAVE YOU HEARD OF AMY LIGHT & ASSOCIATES? ❑ Friend Name:_____

❑ General Dentist ❑ Ortho Patient ❑ Website / Internet ❑ Insurance Plan ❑ Ortho Employee
❑ Yellow Pages ❑ TV / Radio ❑ Direct Mail ❑ Your Company ❑ Billboard / Office Sign

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IF PATIENT IS AN ADULT

EMPLOYER:_____ SPOUSE: _____

ADDRESS:_____ EMPLOYER:_____

POSITION:_____ ADDRESS:_____

PHONE NUMBER: ( ) _____ PHONE NUMBER: ( ) _____

SOCIAL SECURITY #:_____ SOCIAL SECURITY #:_____

IF PATIENT IS A CHILD

PARENT/LEGAL GUARDIAN:_____

EMPLOYER:_____

POSITION:_____

WORK PHONE NUMBER: ( ) _____

SOCIAL SECURITY #:_____

MARITAL STATUS: ❑MARRIED ❑SEPARATED ❑DIVORCED ❑WIDOWED

If Parent/Legal Guardian is <u>not</u> the financial responsible party
(i.e. grandparent or aunt paying account)

FINANCIAL RESP. PARTY:_____

EMPLOYER:_____

POSITION:_____

WORK PHONE NUMBER: ( )_____

SOCIAL SECURITY #:_____

DATE OF BIRTH:_____

PRIMARY ORTHODONTIC INSURANCE OR PRE-PAID PLAN

POLICY HOLDER:_____

BIRTHDATE:_____ EMPLOYER:_____

INSURANCE COMPANY: _____

INSURANCE PHONE: ( ) _____

ADDRESS:_____

POLICY / GROUP #:_____

EMPLOYEE ID #:_____

SECONDARY INSURANCE

POLICY HOLDER:_____

BIRTHDATE:_____EMPLOYER:_____

INSURANCE COMPANY: _____

INSURANCE PHONE: ( ) _____

ADDRESS:_____

POLICY / GROUP #:_____

EMPLOYEE ID #:_____

INFORMATION AND PAYMENT AUTHORIZATION RELEASE

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBE FOR ALL COSTS OF DENTAL TREATMENT AND AUTHORIZE PAYMENT DIRECTLY TO AMY LIGHT & ASSOCIATES OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____/_____

SIGNATURE (Responsible Party) DATE

NEW PATIENT QUESTIONNAIRE

Name _____ **Acct #** _____ **Date** _____

The following questions are designed to obtain your health history and to help us understand what you want to achieve from orthodontic treatment. We will confirm this information when we present your treatment options.

Chief concerns regarding my teeth are: _____

HEALTH INFORMATION:

Does the patient have or has the patient ever had any of the following? *(Please check all that apply.)*

❍High/Low Blood Pressure	❍Diabetes	❍Asthma/Hay Fever	❍Jaundice
❍Rheumatic Fever	❍Venereal Disease	❍Epilepsy	❍Aids/HIV
❍Hepatitis	❍Fainting Spells/Seizures	❍Radiation Therapy	❍Pregnancy
❍Heart Trouble	❍Arthritis	❍Stomach Ulcer	Due date: _____

❍Yes ❍No Does patient require antibiotics prior to treatment? _____
❍Yes ❍No Is patient in good health?
❍Yes ❍No Has there ever been trauma to patients face/teeth? Explain_____
❍Yes ❍No Is the patient presently under the care of a physician for an illness or disease?
❍Yes ❍No Does the patient have a bleeding tendency or do wounds heal slowly?
❍Yes ❍No Is the patient allergic to nickel, latex or any drugs or medications? List: _____
❍Yes ❍No Is the patient taking any medications? List: _____

Signature: _____

CHECK ALL STATEMENTS BELOW THAT APPLY TO <u>THE PATIENT:</u>

The Teeth

- ❍ There are spaces between the teeth that I do not like.
- ❍ The teeth are crooked and overlapping.
- ❍ The teeth stick out too far.
- ❍ The mouth seems too small, not enough room for the teeth.
- ❍ The teeth are coming in the wrong places.
- ❍ Not aware of any problems.

The Bite

- ❍ The bite is comfortable and I can eat what I want with no difficulties.
- ❍ I feel there is a problem with the bite or I have been told there is a problem.
- ❍ I have frequent or chronic pain in my jaws, face or head.
- ❍ My jaws click, pop, or lock when I open my mouth.
- ❍ I have or have had difficulty in opening and/or closing my jaws.
- ❍ I clench my teeth during the day or grind my teeth during the night.

The Dentist

- ❍ I visit the dentist regularly, at least every _____ months.
- ❍ My last cleaning was in the month of _____.
- ❍ I have not seen the dentist for over a year. I am due for a cleaning.
- ❍ It has been _____ years since I had my teeth checked by the dentist.

Dental Problems

- ❍ I have no dental problems that I am aware of other than misaligned teeth.
- ❍ I am aware of other dental problems that need attention._____

- more-

The Orthodontist

- ❍ This is my first experience with an orthodontist.
- ❍ The patient has worn braces before. _____ (year)
- ❍ I have seen another orthodontist and I would like a second opinion. _____ (Dr. name)

What I Expect from Orthodontic Treatment

- ❍ I want all the teeth straightened and the bite corrected if possible.
- ❍ I want the upper and lower teeth straightened and aligned.
- ❍ I only want the upper teeth straightened and aligned.
- ❍ I only want to find out if any treatment is needed.

What Kind of Braces Do You Want?

- ❍ The least expensive (silver metal)
- ❍ The most cosmetic (clear ceramic)
- ❍ Removable and cosmetic (Invisalign)
- ❍ I need more information to make a decision.

Cost and Payment Plans

- ❍ I am interested in saving the most money by paying for the total treatment at the beginning.
- ❍ I am interested in making a down payment to reduce the total costs. $ _____ (amount)
- ❍ I am looking for a payment plan with monthly payments of $_____ per month.

Insurance

- ❍ I have insurance that may pay for a portion of the treatment costs. _____ (provider)
- ❍ I have no insurance that covers orthodontic treatment.

How Soon Would You Like to Get Started?

- ❍ I would like to get started as soon as possible if it is determined that treatment is indicated.
- ❍ I want to meet with the orthodontist to discuss the results of the diagnosis before making a decision.
- ❍ I want to discuss the findings with my spouse before making a decision to start treatment.
- ❍ I want to delay treatment as long as possible.

Patient Age: _____ years _____ months (if under 19)

Communication (preferred language): _____

Best Time to Call Back: _____ Phone: (_____) _____ - _____ E-mail: _____

Patient consent for use and disclosure of protected health information

I have read and received the Notice of Privacy Practices and hereby give my consent for Amy Light & Associates to use and disclose health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO).

_____ _____ _____

Please print name **Signature** **Date**

TREATMENT COORDINATOR NOTES

Set Up Next Appointment: _____

_____

_____

Treatment Coordinator Signature: _____ Date: _____