

HEALTH HISTORY

Has an orthodontist been consulted previously? Yes No
 Are you having jaw pain or discomfort at this time? Do Yes No
 you feel very nervous about having ortho treatment? Yes No
 Are you taking any medications, drugs or pills? Yes No
 If yes, reason:

Are you aware of being allergic to or have you ever reacted adversely to any medication or substances (Such as latex or any metals) Yes No

If yes, please list:

Do you require medication prior to dental procedures? Yes No

If yes, please list:

What are your primary concerns regarding your smile?

Indicate which of the following you have had or are present.

Circle Yes or No

Adenoids Removed	Yes	No	Cosmetic Surgery	Yes	No	Liver Problems	Yes	No
AIDS/HIV	Yes	No	Diabetes	Yes	No	Kidney Problems	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	Mental Health Issue	Yes	No
Anorexia/Bulimia	Yes	No	Endocrine Disorders	Yes	No	Mononucleosis	Yes	No
Arthritis	Yes	No	Epilepsy or Seizures	Yes	No	Nervousness	Yes	No
Asthma	Yes	No	Fainting or Dizziness	Yes	No	Pneumonia	Yes	No
ADD	Yes	No	Hearing Loss	Yes	No	Pregnant	Yes	No
Birth Defect	Yes	No	Heart Pacemaker/	Yes	No	Rheumatic Fever	Yes	No
Hereditary Problems	Yes	No	Surgery	Yes	No	Rheumatism	Yes	No
Blood Transfusion	Yes	No	Heart Trouble	Yes	No	Scarlet Fever	Yes	No
Bruise Easily	Yes	No	Hemophilla	Yes	No	Sickle Cell Disease	Yes	No
Chemotherapy	Yes	No	Hepatitis A	Yes	No	Sinus Trouble	Yes	No
Cold Sores	Yes	No	Hepatitis B	Yes	No	Skin Disorder	Yes	No
Cortisone Medicine	Yes	No	Immune Disorder	Yes	No	Stroke	Yes	No

Additional comments or any other information that you can share that will aid us in treating you?

Are you on a special diet? Yes No
 If yes, what?
 Do you have any disease, condition or problem not listed? Yes No
 If yes, what?
 Have there been any injuries to the face, mouth, or teeth Yes No
 If yes, what?
 Have you ever sucked a thumb or finger? Yes No
 If yes, are you still?
 Do you have any speech problems? Yes No
 If yes, what?
 Are you a mouth breather? While awake? Yes No While asleep? Yes No
 Have you ever been informed of any missing or extra permanent teeth? Yes No
 If yes, which ones?

I have read and understand the proceeding questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

CONSENT:

The undersigned hereby authorizes Capital Family Orthodontics to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of my dental needs. I also authorize Capital Family Orthodontics to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that CFO choose to employ such assistance as deemed fit.

_____ Date:

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and service to your family. Please review our office's financial policy and acknowledge your understanding of this document with your signature at the bottom of the page. If you have any questions, please discuss them with our billing staff or office manager.

Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we accept cash, check, Visa, MasterCard, American Express & Discover.

- **Your insurance coverage is a contract between you and your insurance company.** As a courtesy, upon verification of coverage, we will file an insurance claim for orthodontic treatment on your behalf. If your insurance company does not pay the practice within a reasonable period, we will look to the subscriber of the plan for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

↳ *If orthodontic treatment is still being rendered but your insurance has terminated, you are responsible for paying the remainder which was not satisfied by your plan. If your insurance has terminated because of new employment or a change in coverage, we request that you provide the practice with new insurance details within **thirty days** of the change in order to avoid financial complications with treatment.*

In the case of a divorce, regardless of decree, **the parent who brings the child to his/her appointment is responsible to pay** for the child's services. Reimbursement must be made between the divorced parties. **We will not intervene.**

Our office is committed to making orthodontic care easy and affordable for all our patient families. We offer an in-house, zero interest payment plan with varying down payment options based on the type of treatment. We also partner with Sunbit, a third-party financial institution that has up to an 85% approval rate.

APPOINTMENT CANCELLATION POLICY – We kindly request that you provide us with **24-HOUR**

NOTICE should you need to reschedule an appointment. Appointments that are missed or rescheduled LESS THAN THE 24 HOUR required notice will be charged a Cancellation Fee:

*Cancellation of a routine Orthodontic Appointment such as an adjustment or bonding is \$25 per child, per visit.

*Cancellation of an Orthodontic Appointment such as application of braces or scanning for Invisalign will result in the requirement to **satisfy the down payment** listed on your orthodontic treatment proposal.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature

Date

Understanding Orthodontic Insurance

Orthodontic insurance is vastly different from dental insurance benefits. Your orthodontic coverage is not based on what you need or what your orthodontist recommends. It is based on how much your employer pays into the plan. When deciding on starting orthodontic treatment, your plan benefits should not be the only thing you consider—the best treatment plan for your overall dental health should be determined by you and your orthodontist.

General Orthodontic Benefit Information:

- Orthodontic insurance is often viewed as a lifetime benefit. Once you use any or all the benefit on your plan, it will not replenish yearly as dental benefits do.
- Orthodontic benefits are paid over the duration of treatment, not in one lump sum. Since orthodontic treatment is carried out over the course of several months, insurance companies will pay on a monthly, quarterly, or yearly basis.
- Orthodontic benefits are determined one of two ways; either it is covered at a percentage, or the treatment fee will meet the lifetime maximum.
- Your plan may require a waiting period to be satisfied before any orthodontic benefits will be considered.
- Dependent on the coverage, there may be an age limit that applies to family members listed on the plan. The age limit can range from 16-26 years old.
- Your plan may require a deductible to be paid toward orthodontic treatment before coverage is considered.
- Some plans are required to pay the subscriber directly for orthodontic benefits instead of paying to the provider.

Preferred Providers:

- The plan may want you to choose dental care from its network of preferred providers. This term means that certain dentists have a contract with that specific dental plan; it does not mean that these are orthodontists that patients prefer. If you receive orthodontic care from a doctor who is not in the network, you may have higher out of pocket costs.

Dual Insurance Plans:

- Coordination of benefits is a term that is used when deciphering who is the primary and secondary insurance holder. Even though you may have two or more dental/orthodontic plans, there is no guarantee that your plans will pay for all of the services leaving you with little to no out of pocket cost. Each insurance company handles COB in its own way, so please refer to your plan details for further clarification.

I acknowledge that I have been made aware of the general innerworkings of orthodontic insurance. I also understand and agree that the terms may be amended from time to time either by the practice and/or by the insurance companies in which Capital Family Orthodontics may bill to.

Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have been informed of and understand the
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only:

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communications barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (please specify)

