ORTHOROKS

Patient Biographical Information			
First Name:	**Middle Initial:**	**Last Name:**	**Birthdate:**
Address:	**City:**	**State:**	**Zip:**
Contact Number:	**Email:**	**Social Security #:**	

Responsible Party Information			
First Name:	**Middle Initial:**	Last Name:	**Relationship to Patient:**
Cell Phone:		**Home Phone:**	
Employer:		**Employer Address:**	
How did you hear about us?			

Insurance Information			
Insurance Company Name (Please write N/A if you do not have one:		**Insurance Company phone:**	
Ins. Company Address:	**City:**	**State:**	**Zip:**
Subscriber ID:	**Group Number:**	**Birthdate:**	
Do you have dual dental coverage? **(If yes, complete information below)**			
Insurance Company Name:		**Insurance Company Phone:**	
Subscriber ID:	**Group Number:**		

Emergency Contact		
Name:		
Relationship to Patient:	**Cell Phone:**	**Home Phone:**

Medical History		
Do you have a personal physician?		
Physician Name:		
Physician Phone:	**Date of last visit:**	**Patient Health:**

List of Prescribed drugs:					
For Women:					
Have you started your periods?					
Are you using a prescribed method of birth control?					
Are you pregnant or nursing?					
Have you ever had any of the following:					
Abnormal Bleeding		**Anemia**		**Artificial bones/joints/valves**	
Arthritis		**Asthma**		**Blood Transfusions**	
Cancer/Chemotherapy		**Congenital Heart Defect**		**Diabetes**	
Difficulty Breathing		**Drug/Alcohol Abuse**		**Emphysema**	
Epilepsy/Seizures/Fainting		**Glaucoma**		**Heart Attack/Stroke**	
Heart Murmur		**Hemophilia**		**Hepatitis**	
High/Low Blood Pressure		**HIV+/AIDS**		**Hospitalization for Any Reason**	
Kidney Problems		**Mitral Valve Prolapse**		**Psychiatric Problems**	
Radiation Treatment		**Rheumatic/Scarlet Fever**		**Sever/Frequent Headaches**	
Shingles		**Sickle Cell Disease**		**Sinus Problems**	
Tuberculosis (TB)		**Ulcers/Colitis**		**Venereal Disease**	
Other:					
Are you allergic to any of the following?					
Acetaminophen		**Aspirin**		**Codeine**	
Dental anesthetics		**Erythromycin**		**Ibuprofen or NSAID's**	
Latex		**Any metal or plastics**		**Penicillin or other antibiotics**	
Tetracycline			**Other:**		
How often do you brush your teeth?			**How often do you floss?**		
What are the main concerns that you would like the orthodontist to accomplish?					
Have you ever been evaluated or orthodontic treatment?			**Have you had any major issues with dental work?**		
Do you now or have you ever experienced pain/discomfort in your jaw join (TMJ/TMD)?					
Do your gums ever bleed?			**Have you ever had an injury to our mouth/teeth/chin?**		
Do you clench or grind your teeth?			**Do you have any speech problems?**		
Do you generally breathe through your mouth?			**Do you have any missing or extra permanent teeth?**		
Have you ever taken Fosomax or bisphosphonate?			**Do you smoke or use tobacco in any form?**		
I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.					
Signature:			Date:		

Acknowledgement of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

I authorize Orthoroks Orthodontics to discuss personal treatment and finances with the following individual(s):

Signature: Date:

Consent to Dental Photography

I authorize Dr. Richa Dutta, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.
I consent to allow the photographs to be used for the following:

- **Dental Records**
- **Dental Research**
- **Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books**
- **Marketing material including websites, social media, printed materials and patient education.**

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.
I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: Date:

Other Notices

To our private insurance patients
As a courtesy to you, we will be happy to submit for pre-authorization and/or payment to all insurance companies with a completed and signed insurance form
We will initially ask you for only your estimated co-insurance payment. Please understand that this is only an estimate and is based upon the accuracy of the information available to us from your insurance provider. We will also be unable to carry balances unpaid by the insurance carriers longer than 90 days after the initial submission of claims. After three months, we will require all patients to pay the balances in full and be reimbursed directly from their insurance companies. We reserve the right to pursue all delinquent accounts via a third party collection agency or attorney.
Please familiarize yourself with your dental benefits to be aware of deductibles, time restraints, yearly maximums, and your percentage of financial responsibility. We would like you to understand fully the ultimate responsibility for payment is yours. All patients are responsible for payment in full or agreed upon payment plan at the time of service.

**All patients under the age of 18 must be accompanied by a parent or legal guardian on all visits. We reserve the right to charge for broken or missed appointments without 24 hours notice. A fee of $15.00 may be assessed for failure to notify the office.
**A $35.00 service charge will be assessed for all returned checks.

ALL PATIENTS:
We require all patients over the age of 18 to provide us with their Social Security number. Though many insurance companies have unique identification numbers, they are subject to change when your insurance changes. When insurance is involved, we ask you to remember that we are extending credit to you by collecting only percentage or co-insurance payment and billing your insurance company for the balance. In addition, we ask you to remember that your name and date of birth are not always enough to uniquely identify you for your records purposes. If you prefer not to make this information available to us, we will require cash payment in full at the time of your visit.
I have read and fully understand the terms stated above.

Signature: Date: