STUBBS ORTHODONTICS

GENERAL PATIENT INFORMATION

Name: _____ **Gender:**_____ **Birthdate:**_____

Address:_____**City:**_____ **State:**_____ **Zip:**_____

Responsible Party: _____**Relationship:** _____

Cell Phone:( ) _____**Work Phone:** ( )_____

E-mail (For appointment reminders): _____

Has any family member been a patient here before?_____ Name:_____

EMERGENCY CONTACT: _____ **Relationship:** _____

Cell Phone: ( ) _____E-mail: _____

When was your cleaning with a dentist?(MM/DD/YEAR)_____/_____/_____DENTIST?_____

How did you hear about our office?_____FRIEND?:_____DENTIST?_____

SIGNATURE (RESPONSIBLE PARTY):_____**DATE:** _____

IF PATIENT IS AN ADULT:

Name: _____

Employer: _____

Phone number: ( )_____

SSN: _____

Spouse:_____

Employer: _____

Phone number: ( )_____

SSN:_____

IF PATIENT IS A CHILD:

Father:_____

Employer: _____

Cell Phone: ( )_____

SSN: _____

Mother:_____

Employer: _____

Cell Phone: ( )_____

SSN:_____

DENTAL/ORTHODONTIC INSURANCE:

PRIMARY:

Policy Holder:_____

DOB :_____ Member ID: _____

Insurance (state included): _____

Phone:_____

Address:_____

SECONDARY:

Policy Holder:_____

DOB:_____ Member ID: _____

Insurance (state included):_____

Phone:_____

Address:_____

*INFORMATION AND PAYMENT AUTHORIZATION:

I authorize the release of any information relating to this claim and understand that I am responsible for ALL costs of dental treatment.
I hereby authorize payment directly to STUBBS ORTHODONTICS of the group insurance benefits otherwise payable to me.

SIGNATURE (RESPONSIBLE PARTY):_____

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NEW PATIENT QUESTIONNAIRE

NAME: _____ DATE:_____

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

HEALTH INFORMATION:

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

High/Low Blood Pressure	Diabetes	Asthma/Hay Fever
Rheumatic Fever	Venereal Disease/AIDS	Epilepsy
Hepatitis/Jaundice	Fainting Spells/Seizures	Radiation Therapy
Heart Trouble	Arthritis	Stomach Radiation

Please circle Y- yes or N- no
(Y/N) Does the patient require antibiotics prior to treatment?_____
(Y/N) Is the patient in good health?
(Y/N) Has there ever been trauma to the patient's face/teeth?_____
(Y/N) Is the patient presently under the care of a physician for an illness or disease?
(Y/N) Does the patient have a bleeding tendency or do wounds heal slowly?
(Y/N) Is the patient allergic to nickel or any drugs or medications? Please list below:
_____

SIGNATURE (PATIENT/ RESPONSIBLE PARTY):_____

MY CHIEF CONCERNS ARE:_____

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 have my mouth open.
___ 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

MORE

The Dentist

___ I visit my dentist regularly, at least every _____ month(s)
___ My last cleaning was in the month of _____.
___ My family dentist (group) is _____.
___ I have not seen the dentist for over a year. I am due for a cleaning
___ It has been _____ year(s) 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: _____

The Orthodontist

___ This is my first experience with an orthodontist
___ The patient has worn braces before_____ (year)
___ Someone in the family has worn braces _____(who)
___ I have seen another orthodontist and I would like a second opinion _____(DR NAME)

What I expect from Orthodontic Treatment

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

How much time are you willing to commit to Orthodontic Treatment

___ I am willing to commit as much time and resources as required, even if surgery is needed, to get the best cosmetic and functional results.
___ I want the best results that can be obtained without any facial surgery.
___ I want to spend as little time as possible and am willing to accept compromises

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 $_____
__ I would rather not make a down payment
__ I am looking for a payment with monthly payments of $_____ per month

Insurance

__ I have insurance that may pay for a portion of the cost: _____(Insurance)
__ I have no insurance that covers the cost of 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 and meet the doctor at that time
__ I want to meet 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

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PRIVACY NOTICE

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery etc.)
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc) in order to obtain. payment of your account (i.e., to determine benefits, dates of payment, etc.)
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc) in connection with obtaining certification, licensure or accreditation.
- Internally, to all staff members who have any role in your treatment
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To family and close friends, who are authorized to know/ be involved in your treatment
- 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 or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the uses and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk or retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquires to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of violation)

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you or our right to change terms of this Privacy Notice and to make the new notice provision effective of all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

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PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____ **(PATIENT SIGNATURE)**

_____ **(PRINT NAME)**

_____ **(DATE)**

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PHOTO RELEASE

(THIS IS OPTIONAL - IF YOU DO NOT APPROVE OF THE PHOTO RELEASE, YOU MAY SKIP THIS PAGE)

I, _____ (patient/parent name), consent to the use of my personal image to be posted in Dr. Casi B. Stubbs office when deemed appropriate, such as: removal of braces, wearing a Stubbs t-shirt, and office related contests or giveaways.

I understand that Dr. Casi B. Stubbs will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand, however, that Dr. Casi B. Stubbs cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

_____ **(PARENT/ PATIENT SIGNATURE)**

I HAVE READ AND UNDERSTAND THE TERMS OF THE PHOTO RELEASE.

_____ **(PATIENT NAME)**

_____ **(PATIENT/ PARENT SIGNATURE)**

_____ **(IF PATIENT IS A MINOR, PARENT NAME)**

_____ **(DATE)**