Patient Information   Date___________

Patient Name____Birthdate_______________Gender___M___F

Emergency Contact Name/Phone Number ____

Relationship to patient: _________________________________

Address____, ___________________________________

Email address____

Home Phone_______________ Cell Phone_______________ Work Phone_______________

Whom may we thank for referring you to our Orthodontic Practice? ____________________________________

Medical History

Physicians Name:__________________________________Phone Number______________________

1. When was your last physical Examination?______________________
2. Are you under the care of a physician?..Yes ____ No _____
   If yes, for what reason(s)?____
3. Are you presently taking any medications/drugs/pills/herbals/supplements? ………… Yes _________ No______

If yes, please list:____

4. (**Women**) is there a change you are pregnant?............ Yes _________ No _____
   If yes, anticipated due date __________________U
5. Do you smoke, chew or use e-cigarettes?.................. Yes __________ No _____
   If yes, please indicate which one(s), daily frequency and how long? ________________________________
6. Do you have Diabetes? ……………… Yes _________ No _____
   If yes, please indicate……… type 1 _____ type 2___________ Last HbA1c date and level ______________________

Do you have or had any of the following?

AIDS/HIV Positive	___Yes ___ No	Heart Murmur	___ Yes ___ No
Anaphylaxis	___ Yes ___ No	Kidney Trouble/Dialysis	___ Yes ___ No
Anemia	___ Yes ___ No	Tuberculosis or Lung Disease	___ Yes ___ No
Heart Trouble	___ Yes ___ No	Thyroid Problems	___ Yes ___ No
Artificial Joint	___Yes ___ No	Ulcers/GERD	___ Yes ___ No
Asthma	___ Yes ___ No	Leukemia	___ Yes ___ No
Heart Surgery	___ Yes ___ No	Liver Disease	___ Yes ___ No
Heart Pacemaker	___ Yes ___ No	Hearing Impaired	___ Yes ___ No
Rheumatic Fever	___ Yes ___ No	Oral Herpetic Lesions	___ Yes ___ No
Cancer	___ Yes ___ No	Sexually Transmitted Disease	___ Yes ___ No
Abnormal Blood Pressure	___ Yes ___ No	Sickle Cell Disease	___ Yes ___ No
Stroke	___ Yes ___ No	Sickle Cell Trait	___ Yes ___ No
Chemotherapy	___ Yes ___ No	Artificial Heart Valve/stent/graft	___ Yes ___ No
Drug Addiction	___ Yes ___ No	Psychiatric care	___ Yes ___ No
Epilepsy or Seizures	___ Yes ___ No	Chemotherapy/radiaton	___ Yes ___ No
Jaundice	___ Yes ___ No	Sinus troubles	___ Yes ___ No
Cortico Herpetic Lesion	___ Yes ___ No	Osteoporosis/treatment with Bisphosphonotes	___ Yes ___ No
Excessive Bleeding	___ Yes ___ No	Fainting/Dizziness	___ Yes ___No
Glaucoma	___ Yes ___ No	Do you take pre-medication for anything	___ Yes ___ No
		If you pre-medicate for what? ______________________	

7. Have you had any other serious illness, hospitalization or accident? ____ Yes ___ No
8. Have you ever had any excessive bleeding requiring special treatment? ___ Yes ___ No
9. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):
   Local Anesthetic   Penicillin   Codeine   other antibiotics: ____________________
   Latex   Acrylic   Metals   Other: ____________________

Welcome

10. *Are you taking or have you ever taken any of the following medications (please circle if yes):*

Fosamax *Actonel* *Boniva* *for how long?* ___________________________
Aredia *Reclast* *Zometa* *when did you stop?* _____________________

Dental History

*Previous Dentist*____ *Phone Number*_________________________________
*Date of last dental visit?*______________________________
X-rays taken? ___ *Yes* ___*No*
If yes: __________ *full mouth series* ________ *bitewings* ______ *Panoramic*
What was done at your last visit? ____
Why did you leave that dentist? ____
Has any dental treatment been recommended to you that you have not had done? ____

1. *Are you aware of any dental problems?* ……………………………………___ *Yes* ___*No*
   *Explain:*____
2. *Please rate the present condition of your mouth* ***poor*** *1 2 3 4 5 6 7 8 9 10* ***Excellent***
3. *Do you have well water?* ___ *Yes* ___*No*
4. *Is your water fluoridated?* ___ *Yes* ___*No*
5. *Are your teeth sensitive to* _______*nothing* ________ *sweet* _________ *cold* __________ *Heat* __________*Pressure*
6. *Please rate the appearance of your smile:* ***poor*** *1 2 3 4 5 6 7 8 9 10* ***Excellent***
7. *Would you like a whiter smile?* ___ *Yes* ___*No*
8. *Would you like straighter teeth?* ___ *Yes* ___*No*
9. *Have you had your teeth straightened/worn braces?* ___ *Yes* ___*No*
10. *Are you concerned with bad breath (malodor)?* ___ *Yes* ___*No*
11. *Are you concerned with snoring or sleep apnea?* ___ *Yes* ___*No*
12. *Are you concerned with grinding or clenching your teeth (bruxism)?* ___ *Yes* ___*No*
13. *Do you wear a bite guard?* ___ *Yes* ___*No*
14. *Are you aware of possible TMJ problems – does your jaw joint make noise, lock up or create pain?* ___ *Yes* ___*No*
15. *Is there anything else that would be valuable for your dentist to know to best care for you?* ____________________________
    ____

*How often do you brush?*______________
*How often do you floss?*______________
History of trauma to jaw or face ___ *Yes* ___*No*
Food Catching ___ *Yes* ___*No*

1. *Are you having tooth or gum pain at this time?* ___ *Yes* ___*No*
2. *Do you feel nervous about having dental treatment?* ___ *Yes* ___*No*
3. *Have you ever had a bad experience in a dental office?* ___ *Yes* ___*No*
4. *Do your gums bleed when brushing/flossing?* ___ *Yes* ___*No*
5. *Have you ever seen a periodontist?* ___ *Yes* ___*No*
6. *Have you ever had a "deep cleaning" or gum treatments (scaling and root planning* ___ *Yes* ___*No*
7. *Is there anything you would like to speak with the Doctor about in private?* ___ *Yes* ___*No*
8. *Would you be interested in discussing ways to improve your smiled?* ___ *Yes* ___*No*
   *If yes, please explain:*____

What are some of your main concerns that you would like the orthodontics to accomplish?

____
____

Have you ever been evaluated for orthodontic treatment? If so, where?

____
____

Welcome

Have your tonsils or adenoids been removed? If so, when and by what doctor?

____

To your knowledge, are you missing or have extra permanent teeth? Yes or No

Have you ever had an injury to: (select all that apply)

- o *Teeth*
- o *Mouth*
- o *Chin*

Do you have speech problems? If yes, please explain.

____

Primary Insurance

*Insured's Name*______________________________
*Relationship*______________________________
*Birthdate*______________________________
*SS#*______________________________
*Employer*______________________________
*Occupation*______________________________
*Insurance Company*______________________________
*Group #*______________________________
*Member ID #*______________________________
*Insurance Company Address*______________________________
____
*Insurance Company Phone #*______________________________

Secondary Insurance

*Insured's Name*______________________________
*Relationship*______________________________
*Birthdate*______________________________
*SS#*______________________________
*Employer*______________________________
*Occupation*______________________________
*Insurance Company*______________________________
*Group #*______________________________
*Member ID #*______________________________
*Insurance Company Address*______________________________
____
*Insurance Company Phone #*______________________________

*Relationship*______________________ *Phone #*______________________

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I also authorize the dental staff to perform necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance carrier to pay directly to the Dentist or Dentist group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

____ ______________________
Signature of patient (or parent/guardian if minor) *Date*

____ ______________________
Signature of Dentist *Date*

Welcome

Office Policies for Summerville Pediatric Dentistry and Orthodontics

Appointment Policy

You are unique and special to us, and appointment times are reserved exclusively for each patient. Out of respect to you and your busy schedule, we reserve this specific time slot for your care, and make every effort to see you at that appointed time. We appreciate your promptness and ask that you not change your appointment unless absolutely necessary. If you do need to change an appointment, we ask that you give us at least 48 hours notice so that we may make the time slot available to another patient. We realize that unexpected things can happen, but ask for you assistance with this regard.

A missed appointment fee of **$25** will be applied to your account with less than 24 hours notice of cancellation. Repeated failure to keep your appointments without notice may result in our office discontinuing treatment for your children. **Initials ________**

In the event that your account is sent to collections for non-payment you will be responsible for that amount plus any fees that the collection agency charges our office to collect. **Initials________**

All fees for dental services are expected to be paid at the time of treatment. For your convenience, we accept Care Credit, Visa, MasterCard, Cash and personal checks.

Dental Insurance

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. Once your coverage has been verified, we will accept assignment of payment from your insurance company. Please know that insurance will not guarantee payments therefore, any amount that they do not pay will be your responsibility. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and the estimated co-payment. Your co-payment is expected to be paid at the time of treatment**. For your convenience, our office will gladly process your insurance on your behalf, understanding that the agreement you have with your insurance company is between you and them.** Therefore, you are responsible for any claims which remain outstanding after 60 days, and a finance charge may be applied to any balance due after this time. Payment will be expected on any such claims, and no further attempt will be made by our office to collect from the insurance company in this event.

We will not bill a third party other than insurance companies.

If you have any questions regarding this policy, please speak with someone from our office prior to treatment. We will not alter financial arrangements once treatment has been started.

I have read the above financial policy and understand my obligation to Summerville Pediatric Dentistry and Orthodontics.

Please **print** name ____

____________________________________ ______________________________

(Responsible party signature) (DATE)

Welcome

Acknowledge of Statement of Privacy

I acknowledge that a copy of the Statement of Privacy Practices for the office of Summerville Pediatric Dentistry is available to me. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices is also posted in the facility.

Summerville Pediatric Dentistry and Orthodontics reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. A copy of the revised Statement of Privacy Practices will be available upon request and will be posted in the facility.

I give my permission to Summerville Pediatric Dentistry and Orthodontics to use my and/or my child's picture on their website for educational purposes.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (PLEASE SPECIFY):____________________________	YES	NO

Katie Bullwinkel, DMD, MS
405 W. 5th North Street • Summerville, SC 29483 • (843) 821-6433 option 5

Welcome