Capps & Woods Orthodontics

WELCOME TO OUR OFFICE

ADULT PATIENT INFORMATION

Today's Date:____________________

Name:____ Prefer to be called:_______________ Sex:_______

Home Address:____________________________________ City:______________ State:_____ Zip:______

Home Phone:__________ Age:____ Social Security #______-______-_______ Birthdate:_____________

Cell Phone: _________________ E-mail address:____

Dentist's Name:________________________________

Do you know a patient currently in our practice? If so, whom: _____________________________________

Has any member of the family had orthodontic treatment? If so, by whom? __________________________

Please list names of other family members treated in our office ____________________________________

Who noticed your orthodontic problem? Self Dentist Other __________________________________

Describe your orthodontic problem in your own words:____

What concerns you most about orthodontic treatment?

Appearance in appliances cost length of time discomfort results other_______________

Occupation: ____

Employer:___________________________ Address_____________________ Wk. Phone______________

How long with this employer? ____

Whom may we thank for referring you to our office? (Circle all that apply)

- Word of mouth Social media Doctor:____
- Internet search Drive-by Other person:____

Family And Account Information

Spouses Name:___________________ Employer:______________________ Wk phone: ______________

Person responsible for account: ____

If other than self or spouse:

Name: _________________________________ Occupation:___________________________________

Address: ______________________________ City:_____________ Zip:_____________Phone: _________

In case of an emergency, please provide name, address and phone number of your nearest relative:

Name: ____________________Address:______________________________ Phone: _________

INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee):____________________Date of Birth: ________ Social Security: ____________

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: ____________________________ Address: ________________________ Phone: _________________

Have you ever experienced any health problems? No Yes Explain: ____

Any major change in your health recently? No Yes Explain: ____

Are you currently under a physician's care? No Yes Explain: ____

Are you currently taking any medications? No Yes List: ____

Are you allergic to any medications? No Yes List: ____

Have you received a blood transfusion? No Yes Reason: ____

Have your tonsils or adenoids been removed? No Yes When: ____

Please check if you have had any of the following conditions:

Heart Murmur/Surgery… No Yes	Hepatitis…………. No Yes	Emotional Problems…. No Yes
AIDS……………………. No Yes	Diabetes…………. No Yes	Frequent Headaches…. No Yes
Rheumatic Fever………. No Yes	Kidney Disease… No Yes	Nervous/Anxious……..No Yes
Endocrine disorders…… No Yes	Liver Disease..….No Yes	Cancer…………………No Yes
Prolonged Bleeding…… No Yes	Tuberculosis……. No Yes	Bone Disorders……….No Yes
Anemia…………………. No Yes	Bronchitis………. No Yes	Growth Disorders…….No Yes
Blood Disease………… No Yes	Asthma…………. No Yes	Mouth Breather……….No Yes
Developmental Disorder. No Yes	Epilepsy………… No Yes	Herpes (Fever Blisters).No Yes
Hives/Rash…………… No Yes	Fainting…………. No Yes	Tonsillitis……………..No Yes

Is there any other condition or problem that you think we should know about? ___________________________________

DENTAL HISTORY

Dentist's Name: ________________________________ Address: ___________________________ Phone: ___________

Dental Specialist's Name: _________________________ Address: ___________________________ Phone: ___________

Dental checkups: 2 times a year 1 time a year Only if problem exists Never Date of Last Visit:____________________

Is there any unfinished care to be completed with your dentist? No Yes Explain: ______________________

Are you frightened about dental treatment? No Yes Explain: ______________________

Have you had an unpleasant experience in the dental office? No Yes Explain: ______________________

Have you had any facial or dental injuries? No Yes Explain: ______________________

Do you play any musical instruments? No Yes What instrument:_______________

Have you consulted an orthodontist previously? No Yes With whom: ___________________

Have teeth (either primary or permanent) been removed? No Yes Which teeth: __________________

Have you had any previous orthodontic treatment? No Yes With whom:__________________

Are you satisfied with prior treatment? No Yes Explain: ______________________

Any changes in your bite or dental alignment recently? No Yes Explain: ______________________

Please check if there is a history of:

Clenching teeth Muscular Soreness around head & neck Jaw joint soreness Jaw joint popping

Grinding teeth Headaches (more than normal) Jaw joint clicking Ringing in the ears

Speech problems (if so what sounds ________________) Mouthbreathing- Awake _______ Asleep _______

Snoring Smoking

Is there any other information which may be helpful? ____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial report.

____ ____

Patient Signature **Date** **Reviewed by** **Date**

CAPPS & WOODS ORTHODONTICS
OFFICE POLICIES

Financials:

- It is agreed that if your account becomes delinquent for more than 90 days we will no longer be able to see any patient for their regular visits until your account is brought up to date.
- If you opt to take advantage of our in house, interest free financing, we do require you set up a monthly auto draft using the card of your choice.
- You may pay more toward your down payment if you would like to reduce your monthly payment.
- Insurance responsibility is an estimate given by your insurance company's plan benefits. Responsible Party/Patient is responsible for payment of insurance portion upon discontinued coverage or insurance claim denial.
- There is NO interest charged and NO additional charges will be applied IF treatment extends past the given estimated treatment time unless otherwise discussed.
- We wish to stress that the frequency of office visits has no bearing on the monthly payment and thus, the monthly payment schedule does NOT correspond to the number or frequency of appointments, but rather to the total cost paid out over the approximate duration of treatment. The payment schedule is merely a convenient way to meet your financial obligation.

Any additional fees would consist of:

- Non-payment from your insurance provider.
- Excessive orthodontic appliance breakage. In order to keep treatment on track, a fee of $25 will be charged for each subsequent breakage after 5 broken brackets/bands/wires/appliances.
- Replacement of lost or broken retainers. Fees will vary depending on the type of retainer that is required. ($235 and up per retainer)
- Please be aware, there will be a $35.00 charge for any checks returned for insufficient funds.
- An additional charge of $350.00 per arch is required for clear/ceramic brackets.

Our fee includes all appliances, all appointments, any records taken during treatment, upper and lower retainers at the end of treatment, and 12 months of retainer checks after braces/appliances have been removed. An office visit fee of $65 will be charged after the 12 month period for routine retainer checks. General dental care, six months exams, and restorative treatment for cavities are the responsibility of your general dentist.

Appointments:

- Regular adjustment visits will be scheduled approximately every 6-12 weeks.
- If the patient is experiencing a true orthodontic emergency we will be available for scheduled comfort care appointments as a courtesy to you.
- We will do our best to accommodate before and after school appointments. However, due to appointment type, length, or availability these prime appointments are not always available. With this in mind we do provide school and work excuses for each visit.
- You are more than welcome to go back to the clinic area with your child during their appointments. However, in most cases, we encourage that you to remain in the lobby. This helps your son/daughters learn to trust our staff and the doctors if they are anxious in the early stages of his/her treatment. If you have any concerns Dr. Capps or Dr. Woods would be more than happy to discuss them at any time.

I, as the responsible party for this account, certify that I have read this agreement and that all diagnostic materials and treatment alternatives have been explained to me. I also allow the use of this patient's diagnostic records for research or education purposes.

______________________________ ____________________

Signature of Responsible Party **Date**

WE LOOK FORWARD TO HELPING OUR PATIENTS ACHIEVE A GREAT ORTHODONTIC RESULT!
On behalf of everyone here at Capps and Woods Orthodontics, we thank you in advance!

Capps and Woods Orthodontics

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable laws. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change the Notice and make a new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations: For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patient Rights sections of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Persons Involved In Care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity of emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Patients name ______________________________________ Relationship to Patient _______________________

Signature ____ Date _________________________