Board Certified Orthodontist
10618 Spotsylvania Avenue, Fredericksburg, VA 22408
Office Phone Number: 540-898-7211 Fax Number: 540-898-5081
www.fredbraces.com info@fredbraces.com
Please answer all questions to the best of your ability. This information is important for your health and our records

WELCOME TO OUR OFFICE

Patient's Full Name_____ Date of Birth _____SSN: _____
Physical Address (required for billing insurance)_____
City/State_____ Zip Code_____ Gender _____
Home Phone _____ Cell Phone _____ Work Phone _____
School _____ Full Time Student? _____ Part Time Student? _____
Email _____ Have any family members been treated at our office? _____
Marital Status: [ ] Single [ ] Divorced [ ] Married [ ] Partner [ ] Separated [ ] Widowed

Responsible Party:_____Relationship:_____ SSN:_____DOB:_____
Marital Status: [ ] Single [ ] Divorced [ ] Married [ ] Partner [ ] Separated [ ] Widowed
Home Phone _____ Cell Phone _____ Work Phone _____
Address (if different from above) _____
Employer Name _____
Employer Address _____ City, State_____ Zip Code_____

EMERGENCY INFORMATION

Name: _____Relationship:_____Address if Different _____
_____Home: _____ Work: _____ Cell: _____

INSURANCE INFORMATION

Do you have Orthodontic Insurance? YES NO If yes, please complete the following:

Insured's Name_____ Date of Birth_____ Insured's Social Security #_____
Insured's Address and Phone number **(if different from Responsible Party)**_____
_____Relationship to Patient_____
Insured's Work Phone Number: _____ Cell Phone Number: _____
Insurance Company _____ Policy #_____Group #_____

Do you have secondary insurance? YES NO If yes, please complete the following:

Insured's Name_____ Date of Birth_____ Insured's Social Security #_____
Insured's Address and Phone number **(if different from Responsible Party)**_____
_____Relationship to Patient_____
Insured's Work Phone Number: _____ Cell Phone Number: _____
Insurance Company _____ Policy #_____Group #_____

I authorize the staff to perform any necessary services needed during diagnoses and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further change to the information I have provided.

Signed: _____ Date: _____

For Office Use Only
Med Hx:
Med alert: ☐ No ☐ Yes
Dentist:
Check-up date:
CC:

Dx:

TP:

R&B:

NV:

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DENTAL HISTORY

Patient Name: _____Date of Birth: _____
Parent/Legal Guardian's Name: _____ Date of Birth: _____
Who may we thank for referring you to our practice? _____
Have any family members been treated at our office?_____
Patient's Dentist Name: _____
Does patient receive regular dental checkups? YES NO Last Dental Exam: _____
Do you require pre-medication for dental visits: YES NO If yes, what ailment? _____
Have any teeth been injured or loosened by a fall or blow? _____
The following are some habits commonly found which may influence tooth position. List info as pertains to patient:
Please indicate the age stopped (if stopped).

Y	N	Thumb sucking _____	Y	N	Snoring _____
Y	N	Tongue Thrust _____	Y	N	Grinding Teeth _____
Y	N	Lip Biting _____	Y	N	Nail Biting _____
Y	N	Mouth Breathing while asleep _____	Y	N	Pen Chewing _____

Does anyone else in the family have a similar dental condition? _____

HEALTH HISTORY

Physician Name: _____ Last visit to Physician: _____
Are any of the following conditions present or in past history?

Y	N	Allergies	Y	N	Rheumatic Fever
Y	N	Heart Ailment	Y	N	High or Low Thyroid
Y	N	Heart Murmur	Y	N	Dizziness
Y	N	Diabetes	Y	N	Fainting
Y	N	Tonsillitis	Y	N	Hepatitis
Y	N	Cold Sores or Blisters	Y	N	High or Low Blood Pressure
Y	N	Asthma	Y	N	Injuries to Face, Mouth or Teeth

Other: _____
Present General Health: Excellent Good Fair Poor
Are you currently under a physicians or specialist care? YES NO If yes, what: _____
_____
Are there any behavior or developmental issues we should be aware of:_____
_____
Do you take any medications? YES NO If yes, medication and reason: _____
_____
Have you ever taken Fosamax, Aetonel or any other medication of this type? (for osteoporosis)_____
Do you have any allergies to medication? _____
_____
Any medical alerts we should know about? (medications, latex, etc.) _____
_____
Do you have any artificial cardiac valves or have had infective endocarditis, congenital heart disease or cardiac transplant?
_____
Have you had any joint replacements? YES NO If yes, what: _____
Describe the reason for your visit today: _____
What is the nature of the problem as you see or understand it? Cosmetic Prevention Function
Please Explain: _____
Are there any problems we may encounter of any sort prohibiting successful treatment? _____

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Signed: _____ Date: _____

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Consent/Acknowledgement – Use and Disclosure of Protected Health Information

I understand that Fredericksburg Orthodontics may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the notice, the terms of the notice may change. To obtain a copy of any current notice, I understand that I can contact the Privacy Officer, Jami McManus at (540) 898-7211.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Fredericksburg Orthodontics to release any and all information to insurance companies or associations, employee groups, employer, government agencies or their third party payers and their agents or employees, either by mail or electronically as may be necessary for completion of all my claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records.

AUTHORIZE TO LEAVE MESSAGES

I authorize the staff of Fredericksburg Orthodontics to leave a message on my home/mobile voicemail, answering machine or other electronic device, or with a person who answers my home phone in regards to my health, my appointment or my financial obligations to the practice.

In order for Fredericksburg Orthodontics to disclose Protected Health Information to someone other than you, you must complete this authorization.

_____ _____

Name of Patient (Please Print) **Date of Birth**

May we contact you by: **Email** – Yes / No **Text** – Yes / No

I authorize Fredericksburg Orthodontics to disclose information on my health care to the following person(s).

( ) Spouse_____

( ) Other (Please Identify) _____

This authorization is valid until:

( ) _____ date/event ( ) One year from date I sign this form ( ) Indefinitely

Person to Call if Unable to Reach You

Name: _____

Relationship: _____ Phone #:_____

Authorized Person(s) to Speak with Regarding My Account:

( ) Spouse _____ ( ) Other (please identify) _____

_____ _____

Signature of Patient (Or Parent/Legal Guardian) Date

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FINANCIAL POLICY

(PLEASE READ ALL OF THE BELOW BEFORE SIGNING. NOT SIGNING OR MARKING THROUGH THIS FORM DOES NOT ELIMINATE YOU FROM ANY OF OUR POLICIES, IF YOU AGREE TO TREATMENT, THESE POLICIES WILL BE ENFORCED)

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY: I understand that I will be responsible unless otherwise specified in another written contract, for all services rendered to the patient. I agree to pay for services rendered, in full at time of service, unless other arrangements are made in advance with this office. Whether or not I have insurance, I as a patient/guarantor am responsible for the charges for services rendered to the patient. I further understand that I will be responsible for any additional charges for services which may not be available at the time of leaving the office. I agree to pay for any attorney fees or collection fees that result in the pursuit of collection for services rendered. I also authorize employment verification if needed.

DEDUCTIBLE: An amount you must pay first out of your own pocket each year before your insurance will pay for any service.

ALLOWABLE AMOUNT: Payment amount your insurance company allows for the charges billed.

CO-INSURANCE: an amount which is usually a percentage of the allowable amount that your insurance company will not pay. For example, if your insurance company pays 50%, you are responsible for 50%.

If you have two (2) insurance plans, it is your responsibility to inform us which plan is your **PRIMARY (first) coverage and which plan is your **SECONDARY** (second) coverage, you must inform us if one or both insurance plans change or are no longer effective. Please note we will only file to 2 insurance companies per patient; additional insurance filing will be the responsibility of the subscriber.

PAST DUE ACCOUNTS: We make every attempt to work with patients for an agreeable amount if payments need to be made on balances left from insurance, however if it becomes necessary to collect any sum of money through an attorney, then the patient/guarantor agrees to pay any and all reasonable costs of collection, including attorney's fees, whether suit is filed or not. In the event the account is taken to court, patient/guarantor is responsible for any and all court costs incurred.

TRANSFER OR CREDIT BALANCE: A credit balance resulting from payment to Fredericksburg Orthodontics from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

DIVORCED/SEPARATED PARENTS: The parent bringing the child for treatment is responsible for any co-pay due at the time of service or balances left after insurance. We, the physician's office do not get involved with the financial arrangement between the parents. That is an issue that must be resolved by the parents.

NO SHOW APPOINTMENTS: There will be a $25 fee for all missed appointments.

We will need a copy of the front and back of your insurance card at your initial visit. We expect you to inform us of any change in coverage that may occur and provide us with an insurance card to copy at that time. We will also need a copy of your photo ID.

_____
Patient Name

_____ _____
Patient or Legal Guardian Signature Date

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Authorization to Treat Minor in Absence of Parent/Guardian

Name of Minor Patient: _____ DOB: _____

I certify that I _____ am the parent and/or legal guardian of the above patient.
(Name of Parent/Legal Guardian)

- I authorize _____ to bring my child to office visits with the doctors of Fredericksburg Orthodontics.
- I authorize the minor child named above to come alone to office visits with the doctors of Fredericksburg Orthodontics and I consent to the examination and/or treatment of my child.

This authorization:

[ ] is effective only on _____.

[ ] is effective from _____ to _____.

[ ] is effective indefinitely

Parent/Legal Guardian Contact Information:

Primary Phone Number: _____ Secondary Phone Number: _____

I reserve the right to revoke this authorization at any time by writing to the above-named physician.

Parent/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____