_____ _____ ADULT

JACKSONVILLE
MODERN ORTHODONTICS

Welcome To Our Office!

Please complete the following to help us better care for you

Name: _____ Nick Name: _____

Gender: _____ Age: _____ Date of Birth: _____

Street: _____ City: _____ Zip: _____

Work Phone: _____ Cell/Alt Phone: _____

Occupation: _____ Employer: _____ Years at Employer: _____

E-mail: _____ (for appointment reminders)

Who's your general dentist: _____ When was your last exam? _____

Whom may we thank for referring you? _____

Spouse's Name: _____ Cell Phone: _____

Spouse's Employer: _____ Occupation: _____

Financially Responsible Party: _____ Relationship to Patient: _____

Is there an insurance company which may provide coverage? Yes ☐ No ☐

Insurance Company Name: _____ State: _____

Group/Policy Number: _____ Phone Number: _____

Insured Name: _____ SS #: _____ Date of Birth: _____

Is there a **SECOND** insurance company which may provide coverage? Yes ☐ No ☐

Insurance Company Name: _____ State: _____

Group/Policy Number: _____ Phone Number: _____

Insured Name: _____ SS #: _____ Date of Birth: _____

To the best of my knowledge, these answers are true & correct. I will inform the office with any changes.

Patient Signature: _____ Date: _____

Name:_____ _____ ADULT

JACKSONVILLE
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Medical and Dental History

Please circle any of the following which you have had or presently have

Heart Disease	High Blood Pressure	Heart Surgery
Heart Murmur	Congenital Heart Problems	Artificial Heart Valve
Rheumatism	Artificial Joint	Rheumatic Fever
Growth Disorders	Sleep Apnea	Asthma
Blood Disorders	Bleeding Disorder	Hemophilia
Anemia	Osteoporosis	Hormone Replacement
Therapy	Bisphosphonate	Therapy
Bone Disorders	Diabetes	Thyroid Disorder
Cancer	Stroke	Epilepsy/Seizures
Fainting/Dizzy Spells	Hepatitis	HIV or AIDS
Cold Sores	Allergies to Latex	Allergies to Metals
Allergies to Plastics	Pain/noise in Jaw Joint	

Do you have any disease or condition not listed? If so, please list _____

Have you taken any medications in the last two years? If so, please list: _____

Are you allergic to any drugs or medications? If so, please list _____

Please circle your current health status: Good ☐ Fair ☐ Poor ☐

Women: Are you pregnant? Yes ☐ No ☐

Please indicate your main concerns: _____

Have you ever been treated by an orthodontist or seen an orthodontist for a consultation? _____

If you could change anything about the appearance of your teeth or smile, would you do so? Yes ☐ No ☐

What would you change? _____

What concerns you the most about orthodontic treatment? Appearance ☐ Cost ☐ Discomfort ☐
Length of time ☐ Discomfort ☐ Results ☐

Have you had any periodontal or gum problems? Yes ☐ No ☐

Are you having any pain or discomfort? Yes ☐ No ☐

Have there been injuries to your face, mouth, or teeth? Yes ☐ No ☐

Have you been informed of missing or extra permanent teeth? Yes ☐ No ☐

Are you aware of doing or been told that you do any of the following?

Clenching your teeth	Grinding your teeth	Sore/tired jaw muscles
"Tension" headaches	Migraine headaches	Difficulty opening widely
Popping/clicking jaw joint	Mouth breathing	Tongue thrust

To the best of my knowledge, these answers are true & correct. I will inform the office with any changes.

Patient Signature: _____ Date:_____

JACKSONVILLE MODERN ORTHODONTICS
FINANCIAL POLICY

Assignment and Release
I the undersigned, have insurance with _____, and assign directly Jacksonville Modern Orthodontics all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided by Jacksonville Modern Orthodontics and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that there will be a $35 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 24 hours prior to my scheduled appointment time. ***There may be a fee assessed to my account for excessive last-minute cancellations and missed appointments.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than two hundred fifty dollars ($250) payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a 1.5% monthly finance charge (18% annually). I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Minor/Child Consent
I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Jacksonville Modern Orthodontics

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Jacksonville Modern Orthodontics. I hereby authorize, as indicated by my signature below, Jacksonville Modern Orthodontics to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an unencrypted email/text message at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed:_____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

4._____ Date Added / Removed: _____

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____