KEYSTONE ORTHODONTICS

Park and Scornavacca, PC

1. Patient Information

First Name: _____ Middle Initials: _____ Last Name: _____ Prefers to be called (Nickname): _____ Gender: ○ Female ○ Male

Date of Birth: _____ Responsible Party SSN, ITIN or EIN _____ Relationship to Patient: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. Responsible Party Information (If different from previous listing):

First Name: _____ Middle Initial: _____ Last Name _____ Gender: ○ Male ○ Female

Date of Birth _____ Social Security Number, ITIN or EIN _____ Marial Status ○ Single ○ Married ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____ Email: _____

Preferred Contact Method
○ Mobile Phone ○ Text ○ Email ○ Home Phone ○ Work Phone

3. Responsible Party ID: Please take a photos of your driver's license or government issued identification.

4. How did you learn about our practice or whom may we thank for referring you?

Referral Source:
☐ Google ☐ Dentist or Dental Professional ☐ Social Media ☐ Friend ☐ Family Member
☐ Sign or Billboard ☐ Insurance Provider List

Friend or Family member name:

Other family members being seen my us:

Website or Social Media site:

Other:

5. General Dentist Information

Dentist Name:

Has the patient had a dental visit in the last 6 months?
○ Yes ○ No

Any scheduled dental treatment pending?

6. What is your primary concern(s)?

7. Please take a photo of your teeth that shows your main concern. If unsure, please submit a photo of your smile. (multiple photos accepted)

8. If you had a magic wand, what would you want for your smile?

9. Who suggested that you or your child may need orthodontic treatment?

10. Have you had previous orthodontic treatment?

○ Yes ○ No

11. Do you have orthodontic insurance?

○ Yes ○ No

12. Primary Insurance Information

Primary Insurance Company

Member ID/Policy #

Group Number

Patient Relationship to Insured
○ Self
○ Spouse
○ Child
○ Other

Policy Holder Name

Policy Holder Date of Birth

Policy Holder Phone Number

Street Address:

Apt./Unit #:

City:

State:

Zip Code:

Policy Holder Employer

Policy Holder Occupation

13. Primary Insurance Card: Please take a photo of the front and back of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

14. Secondary Insurance Information

Secondary Insurance Company	Member ID/Policy #	Group Number

Patient Relationship to Insured	Policy Holder Name	Policy Holder Date of Birth	Policy Holder Phone Number
○ Self ○ Spouse ○ Child ○ Other			

Street Address:	Apt./Unit #:	City:	State:	Zip Code:

15. Secondary Insurance Card: Please take a photo of the front and back of your insurance card. Should treatment be recommended, providing your insurance card will allow us to provide you with information about your orthodontic treatment fee that may be covered by your plan.

16. Emergency Contact Information

Name:	Phone number:	Relationship to Patient:

17. Please list the names and ages of any children in the family.

18. Medical History

Name of Physician:	Date of last visit:

19. Check if you have or have had any of the following medical concerns:

- ☐ No Medical Concerns
- ☐ Bleeding Abnormally
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Tobacco Use
- ☐ Angina
- ☐ Chest Pains
- ☐ Emphysema
- ☐ Heart Murmur
- ☐ Hives or Rash
- ☐ Leukemia
- ☐ Psychiatric Care
- ☐ Sinus Trouble
- ☐ Autism
- ☐ Tumors or Growths
- ☐ Anemia
- ☐ Cancer/Cancer Treatment
- ☐ Fainting
- ☐ Heart Attack/Heart Failure
- ☐ HIV/AIDS
- ☐ Rheumatic Fever
- ☐ Anaphylaxis
- ☐ Blood Disease
- ☐ Cold Sores/Fever Blisters
- ☐ Genital Herpes
- ☐ Hemophilia
- ☐ Hypoglycemia
- ☐ Low Blood Pressure
- ☐ Recent Weightloss
- ☐ Spina Bifida
- ☐ ADD/ADHD
- ☐ Ulcers
- ☐ Asthma/COPD
- ☐ Diabetes
- ☐ Acid Reflux/GERD
- ☐ Hepatitis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Alzheimer's Disease
- ☐ Blood Transfusion
- ☐ Drug Addiction
- ☐ Glaucoma
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Parathyroid Disease
- ☐ Shingles
- ☐ Tonsillitis
- ☐ Thyroid Disease
- ☐ Jaundice

Other:

_____

20. Please list any allergies you may have:

_____

21. Please list any medications you are currently taking and the correlating diagnosis:

	Medication Name:	Diagnosis:

22. Are you pregnant?

- ○ Yes
- ○ No
- ○ N/A

23. Have you had any serious illnesses or operations? If yes, please describe.

_____

24. Check if you have or have had history of any of the following dental concerns:

- ☐ No Concerns
- ☐ Thumb/Finger sucking
- ☐ Tongue/Swallowing problems
- ☐ Speech Problems
- ☐ Loose/Broken Permanent Teeth or Fillings
- ☐ Grinding/Clenching
- ☐ Tonsils/Adenoids removed
- ☐ Crowns/Bridges
- ☐ Root Canals
- ☐ Mouth Breathing
- ☐ Snoring
- ☐ Nightguard
- ☐ Periodontal Disease/Treatment
- ☐ Mouth Sores
- ☐ Injury to face or teeth
- ☐ Jaw Pain
- ☐ Jaw clicking or popping
- ☐ Difficulty opening or closing jaw
- ☐ Sensitivity when biting/chewing
- ☐ Sensitivity to hot, cold or sweets
- ☐ Food collection between teeth
- ☐ Teething very early or late
- ☐ Supernumerary (extra) or missing teeth
- ☐ Permanent teeth removed
- ☐ Primary (baby) teeth removed that were not loose

Other:

_____

25. Does patient brush their teeth conscientiously?

- ○ Yes
- ○ No
- ○ Sometimes

26. Does patient need extra help with instructions?

- ○ Yes
- ○ No

27. Is patient self-conscious about their teeth or smile?

- ○ Yes
- ○ No

28. What treatment option(s) interest you?

- ☐ Clear Aligners
- ☐ Braces
- ☐ Retainers

29. If treatment is recommended, how soon would you like to get started?

- ○ ASAP!
- ○ Within the week
- ○ Within the month

30. What payment option(s) would you like to review?

- ☐ Payment in Full with special courtesy
- ☐ Interest-free payment plan
- ☐ HSA/FSA

31. Is there anything else you would like us to know before your visit?

_____

32. We treat patients of all ages and our office follows the recommendations of the American Dental Association, the American Association of Orthodontists, and the American Academy of Pediatric Dentistry. While we always have an assistant in the room who also serves as a charperone, we do not have parents in the treatment room during actual treatment. Dental treatment involves instruments and equipment that is sharp and/or spinning at 400,000 rpms. Even well-intentioned parents inadvertently cause distraction at critical moments, which can result in injury. An exception is the introductory appointment. We will take excellent care of your child. We will involve you in the treatment planning process, we encourage questions, and we will keep you informed of any issues that arise during treatment. All of our decisions are made with your child's dental and overall health in mind.

○ I understand ○ I have questions

33. We are committed to providing you with the best possible care. If you have dental insurance, we want to help you receive the maximum benefits under the policy. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Payment is due when services are rendered unless other arrangements are made. We accept cash, checks, MasterCard/Visa, American Express, and Discover Card. There will be a charge for each returned check or declined credit card or electronic payment. Treatment involving laboratory work, such as dentures and crowns, requires half the fee when we start and the balance at delivery. Unless we receive notice of cancellation 24 hours in advance, you will be charged $50 broken appointment fee. Dismissal may occur at doctor's discretion for missed or broken appointments. If you indicate that someone else is responsible for the cost of your treatment, please remember that ultimately you are responsible for any unpaid balance.

○ I understand ○ I have questions

34. In most cases we will accept assignment of insurance benefits. Medicare is an exception. Your doctor has opted out of Medicare, which provides extremely limited dental benefits. Neither we nor any Medicare beneficiary may bill for or receive payment for services rendered in our office. Other dental benefit plans vary in the amount of coverage they provide, with some covering a high percentage and a wide range of treatment, while others cover lower percentages and fewer procedures. Keep in mind that many pay according to a fee schedule, which might have no relationship to the fees in this area. Remember that the insurance contract is between you (or your employer) and the insurance company; we are not a party to that contract and the responsibility is between you and our office. When we accept assignment of benefits, we are not agreeing to a reduced fee, we are simply allowing that portion of the fee your insurance covers to be paid directly to us by your insurance company. We will estimate your share, including any deductible, based on our experience with your policy, and this amount is due at the time of service. If we do not receive the insurance payment within 60 days, the full balance will be due and payable by you. Any balance over 60 days will incur financial charges at a rate of 1.5% per month with a minimum finance charge of $1.00. Past due accounts may be placed with a collection agency. You will be responsible for all costs of collection which may include collection fees, attorney fees, and any other fees charged by the collection agency including but not limited to a fee for a partial payment made on the past due account. The type of treatment we recommend is based on our professional judgment, not on what your dental benefits cover. We do not believe that it is in your best interest to compromise your treatment in order to accommodate your insurance benefits, which might be less than optimal. Dental benefits are not designed to delineate your treatment needs, but rather to assist you in the cost of treatment. We understand that insurance coverage might play a part in your treatment decisions, but we will recommend what is best for you regardless of insurance coverage. We are happy to discuss the treatment plan with you, thus involving you, rather than your insurance company, in the decision. Alternatively, we will in some cases agree to bill your credit card a set monthly amount. We cannot, however, offer credit to persons unable or unwilling to meet the above options. When granting any credit, we may, at your option, run a credit report in accordance with applicable laws.

- ○ I have read and agree to the above policy
- ○ I have questions

35. For CHIP Members only: We are committed to providing you with the best possible care. If you are covered by CHIP, we want to help you receive the maximum benefits under your policy. In order to achieve these goals, we will need your assistance and your understanding of our payment policy. We will accept assignment of insurance benefits. Remember that the insurance contract is between you and the insurance company, CHIP, and we are not a party to that contract and the responsibility is between you and your office. When we accept assignment of benefits, we are not agreeing to a reduced fee. We are simply allowing that portion of the fee your insurance covers, while active in CHIP, to be paid directly to us by your insurance company. Any balance over 90 days that is not paid by your insurance company due to the termination of coverage is still the patient or the responsible parties' responsibility. If insurance coverage is terminated during treatment, the remaining balance will be determined, and a financial arrangement may be created, or the balance may be paid in full. In this event, please contact our office to make arrangements.

- ○ I understand
- ○ I do not have this insurance

36. In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding and spouse or adult child) must first be authorized. Authorization includes the signature of the individual authorizing the release of information. Information will not be available to anyone other than the covered patient without first having this Release of Information on file. However, parents do have a right to information on children under the age of 18 without the child's consent. I understand that I have the right to revoke this authorization at any time, and that my revocation must be in writing. I understand that the revocation does not apply to information that has already been released in response to this authorization. Checking box below will serve as my signature to release all information to the parties listed below:

○ I agree ○ Do not release my information to anyone

Please list names and relationships to release information:

_____

37. Acknowledgement of receipt of Notice of Privacy Practices

○ Acknowledgement of receipt of Notice of Privacy Practices ○ I would like a copy at my visit

38. I hereby permit Park and Scornavacca, PC to record quotations, photographic images, audio and/or videos of me for any purpose in its sole discretion, which may include, but is not limited to educational, academic, promotional, and/or research purposes. The faculty and staff of Park and Scornavacca, PC may use quotations, photographic images, audio and/or videos of me in any professional manner that Park and Scornavacca, PC believes proper including, but not limited to print publication, video streaming on web sites, podcasting and/or broadcast media. I understand that the quotations, photographic images, audio and/or videos are the sole property of Park and Scornavacca, PC and I will not receive payment or any other type of compensation in connection with the recording or use of the quotations, photographic images, audio and/or videos. I have had the opportunity to discuss this form with the Park and Scornavacca, PC staff and have received answers to all of my questions. I hereby release Park and Scornavacca, PC its employees, officers, and assigns from any and all liability that may arise from the taking or use of the quotations, photographic images, audio and/or videos in any format whatsoever. This release shall remain in effect until revoked by me in writing.

○ I allow use of my images to be used in all medias ○ I decline completely

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

_____ _____

Signature Date