ANDERSON ORTHODONTICS
creating confident smiles

Member American Association of Orthodontists

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Orthodontist
302 Valley Green Square | Le Sueur, MN 56058

Exam Date _____ Dr. _____
Office _____ Model # _____

PLEASE PRINT

PATIENT INFORMATION

Patient Name: _____ ☐M ☐F
First Middle Last
Date of Birth: _____ Age: _____ Hobbies & Activities _____
Address: _____ City: _____ Zip: _____
Home Phone # (___) _____ Referred By: _____

RESPONSIBLE PARTY INFORMATION

☐ Self ☐ Father ☐ Husband ☐ Step Father

Name _____
Address _____
City _____ State _____ Zip _____
Social Security Number _____
Occupation _____
Employer _____ City _____
Phone: Home _____ Business _____

☐ Self ☐ Mother ☐ Wife ☐ Step Mother

Name _____
Address _____
City _____ State _____ Zip _____
Social Security Number _____
Occupation _____
Employer _____ City _____
Phone: Home _____ Business _____

Person Responsible for Account _____ Family Status: M ☐ S ☐ Wid. ☐ Sep. ☐ Div. ☐
Address _____ Phone _____ City _____ State _____ Zip _____
Orthodontic Insurance Coverage ☐ Yes ☐ No

DENTAL INSURANCE

Primary **Dental** Insurance Co.:
Name: _____
Address: _____ Phone: _____
Group #: _____ SS#: _____ (Required) Subscriber Birthdate: _____

Secondary:
Name: _____
Address: _____ Phone: _____
Group #: _____ SS#: _____ (Required) Subscriber Birthdate: _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

_____ _____
DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABILE TO ME.

_____ _____
DATE

DENTAL HISTORY

1. Patient's Dentist: City: Date of Last Visit:
2. Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐ No
3. Have you had or do you presently have any of the following habits? ☐ Thumb or finger sucking ☐ Lip biting ☐ No ☐ Grinding of teeth at night ☐ Mouth breathing
4. Has an orthondontist been consulted previously? ☐ Yes ☐ No
   Name: Date:
5. Have you ever been treated for: ☐ Bad bite ☐ TMJ ☐ Periodontal gum disease
   If so, by whom? ☐ No
6. Do you have any speech problems? ☐ Yes ☐ No
7. Are you frightened or anxious about Orthodontic treatment? ☐ Yes ☐ No
8. Are you concerned about the appearance of your teeth? ☐ Yes ☐ No
9. Is there anything you would like to change about your smile? ☐ Yes ☐ No
   If so what?
10. Reason for consultation:
11. Has there ever been any orthodontic treatment for any other member of your family? ☐ Yes ☐ No If so what?
    If yes, were they treated in our office? ☐ Yes ☐ No Family member name _____

MEDICAL HISTORY

1. Name of patient's physician:
2. Has the patient shown signs of increased growth recently? ☐ Yes ☐ No
3. Is the patient under the care of a physician at this time? ☐ Yes ☐ No
   Explain:
4. Is the patient taking any medication (over the counter or prescription)? ☐ Yes ☐ No
   Name:
5. Is the patient allergic to any medication? ☐ Yes ☐ No
   Name:
6. Has the patient ever had a serious illness or been hospitalized? ☐ Yes ☐ No
   Explain:
7. Does the patient have any special problems not listed? ☐ Yes ☐ No
   Explain:
8. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? ☐ Yes ☐ No
   If yes, antibiotics name and method:

DOES THE PATIENT NOW, OR HAVE THEY EVER HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	Endocarditis	☐	☐	AIDS or H.I.V. Positive	☐	☐	Fainting Spells
☐	☐	Heart Condition If so explain _____	☐	☐	Venereal Disease	☐	☐	Kidney Trouble
		_____	☐	☐	Herpes (oral-cold sores)	☐	☐	Liver Disease
☐	☐	Heart Attack (coronary)	☐	☐	Blood Disorders	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Inflammatory Rheumatism	☐	☐	Headaches
☐	☐	Rheumatic Fever	☐	☐	Arthritis	☐	☐	Earaches
☐	☐	Prosthetic (artificial) Joint	☐	☐	Diabetes	☐	☐	Jaw Clicking
☐	☐	X-ray/Radiation (cancer) Therapy	☐	☐	Ulcers	☐	☐	Allergies If so explain _____
☐	☐	Respiratory Lung Disease	☐	☐	Stroke			_____
☐	☐	High Blood Pressure	☐	☐	Anemia	☐	☐	Jaw Pain
☐	☐	Low Blood Pressure	☐	☐	Asthma	☐	☐	Emotional Problems
☐	☐	Hepatitis	☐	☐	Epilepsy	☐	☐	Other _____
☐	☐	Tuberculosis	☐	☐	Glaucoma			_____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION OR INFORMATION NOT DISCLOSED.

_____
Signature of patient or parent or guardian

_____
Signature of Orthodontist

Today's Date _____

Update _____ Initial _____

Update _____ Initial _____

FOR OFFICE USE ONLY

PRELIMINARY EXAMINATION

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	L
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

	A	B	C	D	E	F	G	H	I	J	
R	E	D	C	B	A	A	B	C	D	E	L
	E	D	C	B	A	A	B	C	D	E	
	T	S	R	O	P	O	N	M	L	K	

Skeletal: AP _____ Mx _____ Md _____ Vertical _____

Dental Class R _____ L _____

Dentition: P M LM A

Arch Discrep Mx _____ Md _____

OB _____ OJ _____

Crossbite ——|——

Special Problems _____

Habit _____

Soft Tissue _____

TMD _____

Missing ——|——

Impacted ——|——

Midline _____ _____mm

Perio _____

TX Plan _____ Ext ——|——

Appl _____

TX Length _____ Fee _____

Records Appt _____ Consult Appt _____

Date

NOTES

GENERAL OFFICE POLICY

The time between adjustment appointments varies anywhere from 3 to 8 weeks depending on the kind of tooth movement or changes we're hoping to make in the correction of the orthodontic problem. Longer intervals between adjustments do not necessarily mean that the treatment is going to be delayed.

Our regular office hours are 8:00 am – 4:30 pm with some exceptions, especially in our satellite offices. Unfortunately we are not able to accommodate every appointment late in the day. Consequently, for longer adjustment appointments or appointments where there has been excessive damage or loose bands, we would request that mid-day appointments be scheduled so that we can keep the patient's treatment on schedule and not become significantly delayed.

Scheduling long appointments such as bandings, debands, and wire changes during the mid-day also helps to accommodate other people and provides more time for the shorter adjustments that we like to save for after school.

The treatment fee does include almost all orthodontic services regardless of treatment duration. In most orthodontic treatments, some elastic wear (rubber bands) will be required by the patient. If the elastics are not worn as recommended, treatment may be significantly delayed and additional charges may be incurred. Removal of braces, fabrication of retainers (the first set) and retainer checks are all included in the total treatment fee. However, there will be a charge for lost or broken retainers. In addition, special retainers are sometimes needed for certain types of bite problems that would benefit the patient's finish and long-term retention. These retainers (called gnathologic positioners), will be used only if approval is given by parents. These situations and any potential charges are always discussed prior to their placement.

Orthodontic records are taken on patients prior to start of treatment. The charge for these records is included in the orthodontic fee; however, if treatment is not scheduled within 45 days from when the records are taken, these charges are billed out separately. In some instances, progress records are necessary to evaluate abnormal jaw growth for people whose treatments do not respond appropriately to conventional orthodontic treatment. Once again, the need and any potential charges for these records are discussed with the family for prior approval before the services are rendered.

For our adolescent patients, a panoramic radiograph is generally taken sometime after the treatment has been terminated to evaluate development of the third molars (wisdom teeth). There is a charge for this radiograph not included in the treatment fee. If the 3rd molars need to be removed, a duplicate radiograph will be sent to the oral surgeons' office at no additional cost.

Patients are given a bottle of fluoride at the banding appointment. There is a charge, however, for additional bottles of the fluoride that we dispense to the patient. A sample of super-floss is also given out at the banding appointment and may be later purchased at a local pharmacy or discount store or one may use regular dental floss with floss aids.

If there are any questions regarding the information that we have provided, please feel free to contact us.

Dr. Jason Anderson and Staff

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.