F&S

Orthodontics and Periodontics

Patient Information

Full Name: _____ Preferred Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: ❑ H ❑ C _____ Email: _____ SSN: _____

Employer: _____ Work Phone: _____ How long employed: _____

Spouse's Name: _____ ❑ Not Married Phone: _____ Spouse Birth Date: _____

Spouse's Employer: _____ Work Phone: _____ Spouse's SSN: _____

Dentist Name: _____ Date of last dental cleaning: _____

How did you hear about us?: ❑ Dentist ❑ Google ❑ Friend/Family Whom may we thank? _____

Send appointment reminders by: ❑ Text ❑ E-mail

Dental Insurance Information Only

❑ Not covered by dental insurance (If no insurance, skip to next section)

Please provide us with your insurance card(s) so we can make a copy

Policy Holder Name: _____ Insurance Company Name: _____

Group Number: _____ ID/Policy Number (may be SSN): _____

Insurance Mailing Address (back of card): _____

Covered by secondary dental insurance? ❑ Yes ❑ No

Policy Holder Name: _____ Insurance Company Name: _____

Group Number: _____ ID/Policy Number (may be SSN): _____

Insurance Mailing Address (back of card): _____

If you're a dependent covered by parent's insurance; complete the following

Who is financially responsible for this account: ❑ Self ❑ Parent

Policy Holder Address (if different): _____ Phone: _____

Policy Holder Birth Date: _____ Policy Holder Employer: _____

Medical and Dental History

Main reason you contacted our office for an exam: _____

_____

Have you ever been examined by an orthodontist/periodontist before? ❑ Yes ❑ No

Did you pursue treatment? ❑ Yes ❑ No

Please explain: _____

_____

Do you have any history of the following?
❑ Cancer or tumor
❑ Heart ailment or angina
❑ Heart murmur, mitral valve prolapse, or heart defect
❑ Rheumatic fever or rheumatic heart disease
❑ Artificial joint or valve
❑ High or low blood pressure
❑ Pacemaker
❑ Tuberculosis or other lung problems
❑ Kidney disease
❑ Hepatitis or other liver disease
❑ Alcoholism
❑ Blood Transfusion
❑ Diabetes
❑ Neurologic condition
❑ Epilepsy, seizures, or fainting spells
❑ Emotional condition
❑ Arthritis
❑ Herpes or cold sores
❑ AIDS or HIV positive
❑ Migraine headaches or frequent headaches
❑ Anemia or blood disorders
❑ Abnormal bleeding after extractions, surgery, or trauma
❑ Hayfever or sinus trouble
❑ Allergies or hives

Do you have any history of the following?
❑ Multiple cavities
❑ Teeth extracted
❑ Teeth abscessed
❑ Gum disease
❑ Nail or lip biting or thumb sucking
❑ Tongue thrust
❑ Poor dental hygiene
❑ Mouth breathing more than nose breathing
❑ Tonsils and/or adenoids removed
❑ Pain or ringing from ears
❑ Frequent ear infections, sinusitis, or swollen glands
❑ **Need to take antibiotics before dental treatment**
❑ Automobile accident causing dental trauma
❑ Obstructive sleep apnea
❑ Snoring or difficulty sleeping

Are you allergic to or reacted adversely to any of the following?
❑ Latex materials
❑ Penicillin or other antibiotics
❑ Local anesthetics ("Novocain")
❑ Codeine or other narcotics
❑ Sulfa drugs
❑ Barbiturates, sedatives, or sleeping pills
❑ Aspirin
❑ Other: _____

Are you taking any of the following?
❑ Aspirin
❑ Anticoagulants (blood thinners)
❑ Antibiotics or sulfa drugs
❑ High blood pressure medication
❑ Antidepressants or tranquilizers
❑ Insulin, Orinase, or other diabetes drugs
❑ Nitroglycerin
❑ Cortisone or other steroids
❑ Osteoporosis (bone density) medication
❑ Other: _____
_____

Do you have any history of the following issues related to the Temporomandibular Joint (TMJ)?
❑ TMJ problems
❑ Clicking, popping, or noise from the jaw during opening or closing
❑ Teeth clenching or grinding
❑ Pain upon wide opening, yawning, or biting hard foods
❑ Frequent neck, shoulder, or back pain
❑ Injuries to teeth, chin, head, or face (falls, blows, etc.)
❑ Prosthetic joint replacement of the TMJ

Females:
❑ May be pregnant
Expected delivery date: _____
❑ Taking hormones or contraceptives

Do you smoke, vape or use chewing tobacco?
❑ Yes ❑ No

Is there anything else you would like us to know about you? _____

_____

_____

Signature of Patient: _____ Date: _____

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Insurance and Financial Policy

At F&S Orthodontics and Periodontics, we believe that you deserve the best dental care available today. We will assist you in maximizing your insurance benefits to obtain that care when the benefits apply to you.

Our practice is a fee-for-service office. Payment in full or setting up a scheduled payment plan is expected at the time of service. We offer interest-free automatic payment plans. The majority of dental reimbursements are sent directly to the policy holder from the insurance company.

You agree to receive calls, text messages, and emails from F&S Orthodontics and Periodontics and its partners. These messages may contain details about products, services, and debt collection in case of unpaid bills. These messages may be sent using automatic systems or recorded voices. Standard message and data rates may apply. You can opt out at any time by contacting us.

Our office is out-of-network for all dental insurance plans. We will submit a claim to your dental insurance company as a courtesy to you. Claims can be submitted to any employer-funded dental plan on your behalf and will be reimbursed at the out-of-network benefit level. ***We are unable to submit to any state-funded dental plans.***

Benefits are based on the terms of the contract negotiated between your employer and the dental insurance company, not your dental office. Therefore, some services may not be covered even though they are necessary. We will do our best to submit claims and answer questions regarding any claim. However, since we are an out-of-network provider we are sometimes limited in working with the insurance companies. We urge you to read over your dental benefits plan so that you are fully aware of coverage and limitations; ultimately, you are responsible for the entire treatment fee.

We highly value your trust in us and will work diligently to assist with submitting to your insurance company. We welcome you and your family to our practice and look forward to helping you achieve a healthy and beautiful smile. If you have any questions regarding our insurance and/or financial policy, please do not hesitate to ask.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____