Appointment:

PACIFICA ORTHODONTICS

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female Referred by: _____

Patient Name_____ D.O.B _____ Age_____

Primary phone #_____Home Tel. _____School:_____

Address _____Email _____

RP/Guardian/Parent's name _____ Relation to patient _____

Marital Status: __Married __ Divorced __ Widow __ Single __ Separated

Employer_____: __ Full time __Part time __Retired __Unemployed

Dentist: _____ Last cleaning: _____x-rays taken? ___

Medical Doctor: _____Office Address /Tel. _____

Emergency Contact: _____ Tel. _____

Siblings/Family in treatment: _____

WHO WILL BE RESPONSIBLE FOR ACCOUNT?

Self ___ (skip this section) Spouse __ Father__ Mother __ Other_____

Name_____ SS# _____ DOB_____ Tel. _____Employer:

Address_____ Email_____

<u>Spouse or other guarantor information:</u>

Spouse __ Father__ Mother __ Other_____

Name_____ SS# _____ DOB_____ Tel. _____Employer:

Address_____ Email_____

INSURANCE INFORMATION

Primary Insured Name	D.O.B	Insurance Company
SS#/ID#	Group Name Group #	Phone number
Secondary Insured Name	D.O.B	Insurance Company
SS#/ID#	Group Name Group #	Phone number

DENTAL INFORMATION

What are your main concerns for this appointment?

- ○ Invisalign
- ○ Braces
- ○ Retainers
- ○ Open to all options

Are you in pain? For how long?

Please indicate any of the following problems:

- ☐ Appearance of teeth/facial aesthetics
- ☐ Crowding/spacing
- ☐ Bite issues: overbite/underbite/crossbite
- ☐ Finger/tongue/thumb habit
- ☐ Missing/extra teeth
- ☐ Oral function
- ☐ Speech problems
- ☐ History of facial neck injury
- ☐ Teeth grinding/clenching
- ☐ Ringing in ears/pain
- ☐ Red/swollen/bleeding gums
- ☐ Food gets caught between teeth
- ☐ Cold sores/ blisters
- ☐ TMJ pain/dysfunction
- ☐ Difficulty opening/closing jaw/ lock jaw
- ☐ Clicking/popping jaw
- ☐ Snoring/Mouth breathing/sleep apnea
- ☐ Other

Times a day you brush _____

Times a week you floss _____

Would you like whiter teeth? _____

Have you ever been examined by an orthodontist?

If yes, who? _____

When? _____

Recommended treatment?

_____

Have you ever had orthodontic treatment?

If yes, please describe:

Sports/Hobbies:

HEALTH HISTORY

Are you in good health?

Are you under the care of a physician?

Do you need to take antibiotics prior to dental treatment?

Have you had any illness, operation, or been hospitalized?

Is the patient adopted?

History of disease, medical conditions, or procedures:

Medications:

Allergies:

Allergic to latex or metals?

PACIFICA ORTHODONTICS FINANCIAL POLICY

Thank you for choosing us for your dental care. We are committed to providing you with excellent care, and payment of your bill is part of successful treatment. Our financial policy is based on open and honest discussion of our fees.

- **FINANCIAL POLICY**

Payment is due at the time of treatment unless other arrangements are made. ***Payment for services of treatment is the responsibility of the adult patient, or legal parent/guardian of the minor patient*** *(should there be more than one responsible party involved, it will be necessary for each to sign an individual contract).*

- **INSURANCE**

As a service to our patients, we will bill your insurance company directly to help maximize your benefits.

I, the undersigned, have insurance with _____

Name of Insurance Company(ies)

and assign directly to ***Pacifica 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 for by the insurance.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

_____ _____

Date **Signature of Patient/Parent/Guardian**

- **USUAL & CUSTOMARY RATES**

Our fees reflect our commitment to the quality our patients deserve and are considered usual and customary for the area, ***regardless of any insurance company's determination.***

- **SERVICE CHARGES**

All accounts that are over 60 days past due (regardless of insurance claim status) will be charged an interest rate of 10% per month.

- **COLLECTION FEES**

Fees incurred from collections will be billed to and payable by the patient.

_____ _____

Date **Signature of Patient/Parent/Guardian**

(Acknowledgement of Receipt of Notice of Privacy Practices)

Purpose: This form is used to obtain acknowledgement of receipt of our ***Notice of Privacy Practices,*** or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's ***NOTICE OF PRIVACY PRACTICES***.

(Please Print Name) _____

(Signature) _____

(Date) _____/_____/_____

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____