

Ericka Sample D.D.S., P.A.
Specialist in Orthodontics for Children and Adults

Patient name: _____ **Nickname:** _____ **Date:** _____
Patient Address: _____ **Phone:** _____
Birth date: _____ **Age:** _____ **Sex:** _____ **Dentist:** _____

Primary Responsible Party: Self Spouse Parents Other (specify) _____
Name: _____ **Address:** _____
Email: _____ **Cell #:** _____ **Mobile Carrier:** _____

Secondary Responsible Party: Self Spouse Parents Other (specify) _____
Name: _____ **Address:** _____
Email: _____ **Cell #:** _____ **Mobile Carrier:** _____

Who may we thank for referring you to our office? Dentist Friend (specify) _____
 Internet Other (specify) _____

Circle Yes or No for which the patient has or had a history of:

MEDICAL HISTORY				HABITS			
Aids	Y N	Cancer	Y N	Hepatitis	Y N	Nervous Disorders	Y N
Allergies	Y N	Cold Sores	Y N	Herpes	Y N	Organ Transplant	Y N
Anemia	Y N	Diabetes	Y N	High Blood Pressure	Y N	Periodontal problems	Y N
Anorexia	Y N	Drug allergies	Y N	HIV positive	Y N	Polio	Y N
Arthritis	Y N	Endocrine problem	Y N	Immune problems	Y N	Pregnant	Y N
Asthma	Y N	Emotional disorders	Y N	Jaundice	Y N	Prolonged Bleeding	Y N
Blood Disorder	Y N	Epilepsy	Y N	Kidney problems	Y N	Scarlet Fever	Y N
Blood Transfusion	Y N	Emphysema	Y N	Low Blood Pressure	Y N	Seizures	Y N
Bone Disorder	Y N	Fainting, Dizziness	Y N	Mononucleosis	Y N	Thyroid Disease	Y N
Bulimia	Y N	Heart conditions	Y N	Muscular disorders	Y N	Tuberculosis	Y N
						Cheek biting	Y N
						Clenching teeth	Y N
						Grinding teeth	Y N
						Lip biting	Y N
						Mouth breathing	Y N
						Nail biting	Y N
						Smoking	Y N
						Speech problems	Y N
						Thumb/Finger habit	Y N
						Tongue thrust	Y N

List any allergies: _____
 Current Medications? _____ Have you taken Bisphosphonates(for Osteoporosis)? _____
 Any diseases or problems not mentioned above? _____
 Females: Has Menstruation begun? _____ At what age? _____ Males: Has voice changed? _____ At what age? _____
 Has the patient seen a General Dentist in the last year? _____ Date last seen: _____
 Describe any clicking or discomfort near the ears? _____
 Describe any face, mouth or teeth injuries? _____
 Are there any missing or extra teeth? List: _____
 Do gums bleed when brushed or flossed? _____ Have the Tonsils and adenoids been removed? _____
 Does patient require Antibiotics before Dental work? _____ Medical Doctor: _____ Phone: _____

Emergency Contact Information:
Name: _____ **Home #:** _____ **Cell #:** _____

Signature: _____ **Relationship to Patient:** _____ **Date:** _____

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Office Policy and Procedure

Hours of operation:

Monday	8:30am-5:00pm
Tuesday	8:30am-5:00pm
Wednesday	8:30am-5:00pm
Thursday	8:00am-3:00pm
Friday	CLOSED

Please be aware that these hours and days of operation may change according to doctor/staff and scheduling needs.

We also reserve the right to reschedule your appointment if you arrive 15 minutes late. Please call if you are to be late in order to save yourself a trip when a reschedule is necessary.

Discounts:

1. If a patient or parent agrees to schedule **ALL** appointments between the hours of 10:00a.m-2:15p.m., a one time discount of \$100.00 off of the total fee for Full treatment will be applied and \$50 off of the total fee for Limited/Phase I treatment will be applied.
2. For multiple family members in treatment, a \$100.00 discount will apply to the total treatment fee beginning with the 2nd family member. This applies to Full treatment/Phase II cases only. Limited or Phase I cases are not eligible.
3. Pay the total treatment fee in full by cash or check and receive a 5% bookkeeping discount off of the total treatment fee.

Appointment Rotation:

For our office to provide quality care to all of our patients equally, our policy requires us to spread patient appointments throughout the day. **In order to effectively do this, it will be necessary for patients to rotate their appointments between morning and afternoon.** The afternoon appointments will be reserved for regular adjustments and quick appointments so we can accommodate more school age patients after school. Long appointments will be scheduled between the hours of 8:30 a.m. and 3:00 p.m.

Missed Appointments:

24 hours cancellation notice is required to avoid missed appointment fee of \$25.00. As a courtesy to our busy parents/patients this charge does not go into effect until the 3rd missed appointment.

Delinquent payments:

We realize falling behind on payments can happen. We can work with you if you communicate with us! If are not be able to make a full payment, please make a partial payment. Call our office to see if we can work out a better payment schedule for you. **If there is a past account for a responsible party, a sibling's treatment will not be started until the past due account is brought current.**

A reminder letter will be sent out to all accounts past due 30 days or more. Collection letters will be sent out upon 60 and 90 days' delinquencies as well. If no attempt is made to bring the account current, we reserve the right to follow with collection procedures. The responsible party agrees to pay all attorney's fees and associated costs. **A past due account is a basis for terminating orthodontic treatment.**

Insufficient Funds (returned checks):

The first check returned to us unpaid will incur a \$25.00 fee. The second will incur a \$25.00 fee and the remaining balance will need to be paid monthly with cashier's check, money order or credit card

Divorced or Separated Parents:

Full payment is the responsibility of the guardian or parent with full or joint custody and who signs the financial contract. This is regardless of the terms outlined in a divorce decree. This is a matter between the divorced parents and the courts. We will not be placed in the middle.

Responsible Party

Date

Insurance Information Request Form

Welcome to our office! In order to best serve you, we need some information for our records. The information we receive is not a guarantee of payment. Insurance will **not** pay for the entire treatment since there may be a deductible, a lifetime dollar limit and, or excluded services. Lost and broken appliances or loose braces are rarely covered.

Patient's Name: _____ DOB: _____

Policy Holder: _____ DOB: _____ SSN: _____

Insurance Company: _____ Phone #: _____

Claims address: _____ City, State, Zip: _____

ID #: _____ Employer: _____

Quote of benefits

When we call the insurance company we request the following:

- Life time maximum on your plan...(each plan differs)
- Percentage of fee paid...(can be from 20% to 80% of charges)
- Age Limit...(may be children to 19 or 26 only)
- Date of eligibility...(there may be a waiting period before you are eligible for orthodontic benefits)

Filing claim forms

Each insurance company has its policy on ways of paying benefits. Some will pay as billed, some will divide the charges over the treatment time and pay quarterly installments and others will only make payments to the insured and not to the provider.

Setting up payment arrangements

Our Treatment Coordinator subtracts the amount of estimated benefits your plan allows from the total cost of your orthodontic treatment and makes arrangements so the balance can be paid. We are happy to accept benefits from your insurance company to make it easier for you, but **any insurance benefits not paid are your responsibility and will be transferred to your contract.**

Important additional information

Please call our office for advice before making any changes to your policy during treatment.

If you do not receive the benefits you believe you are entitled to from your insurance carrier, you need to contact them or your insurance representative in order to dispute any matters.

There are times that your insurance may not pay the estimated amount due to the following possible reasons:

- Deductibles not met
- Change in the way the insurance company pays benefits
- Change in insurance companies
- Termination of the plan or employment
- Some of the maximum was used on previous orthodontics

In addition, the estimated allowable cost incurred by necessary extractions needed for orthodontic treatment may be applied towards your orthodontic benefits.

If ANY of this happens, the balance of the fee is transferred to the guarantor to pay.

Signature

Date