Troy ORTHODONTICS

WELCOMES YOU!

PATIENT INFORMATION: (UNDER 18 YEARS OF AGE)

Date: _____ **Sex:** M or F **Date of Birth:** _____

Patient's Name: _____
Last First Middle *Social Security Number

Address: _____
Street City State Zip

ADDITIONAL PATIENTS (SIBLINGS) (UNDER 18 YEARS OF AGE)

Patient's Name: _____ **Sex:** M or F **Date of Birth:** _____

Patient's Name: _____ **Sex:** M or F **Date of Birth:** _____

RESPONSIBLE PARTY INFORMATION:

Parent #1: _____
Last First Middle

Phone: (Home) _____ (Cell) _____ (Work) _____

Address: _____
(If different from above) Street City State Zip

***Email Address:** _____ **Relationship to Patient:** _____

Parent #2: _____
Last First Middle

Phone: (Home) _____ (Cell) _____ (Work) _____

Address: _____
(If different from above) Street City State Zip

***Email Address:** _____ **Relationship to Patient:** _____

EMERGENCY INFORMATION:

Contact Name: _____ **Relationship:** _____ **Contact Phone #:** _____

How did you hear about our office? _____

***General Dentist & town of practice:** _____ **Date of last visit:** _____

DENTAL HISTORY

PATIENT NAME: _____

What concerns you most about the child's teeth?_____

Yes No Has the patient ever seen an orthodontist? If yes, who and when?_____

Yes No Has anyone in the family received orthodontic treatment?_____

How did they feel about the result?_____

Yes No Is the patient presently in any dental pain?_____

Yes No Has the patient experienced any unfavorable reaction to dentistry?_____

Has the patient ever had any of the following? ***(Please check all that apply to you***

o Lost or chipped any teeth	o Loose teeth	o Snoring
o Injuries to face, mouth, or teeth	o Decayed teeth	o Headaches or migraines
o Sensitive to pressure	o Mouth breather	o Chronic ringing in the ears
o Bleeding gums when brushing	o Teeth or jaws ever feel uncomfortable	o Need extra help with instructions
o Thumb, finger, lip or tongue habit	o Experience jaw clicking or popping	o Sensitive/self-conscious
	o Clenching or grinding of teeth	

MEDICAL HISTORY

PLEASE FILL IN DETAILS:

Please list all medications?_____

Please list all allergies?_____

Is there a history of any major illness?_____

Has the patient had any operations or been involved in a serious accident?_____

Is the patient pregnant? (Female Patients only) _____

Has the patient ever had a CT scan or MRI of the head?_____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that we should be aware of?_____

_____

I have truthfully answered all the questions in the medical and dental history and agree to inform this office of any changes in my medical or dental history.

BENEFITS:

Benefits of Orthodontics: Esthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. In addition, I authorize Dr. Tuhina Roy to perform an orthodontic evaluation. I understand that today my child (children) will be examined and the results of this examination will be discussed with me. If my insurance covers this examination, a claim form will be sent to the insurance company.

***Parent Signature:** _____ **Date:** _____

***Reviewed by Doctor:** _____ **Date:** _____

Troy ORTHODONTICS

DENTAL INSURANCE

(Please allow receptionist to scan your insurance ID cards)

NJ FAMILY CARE

PLEASE CIRCLE YOUR INSURANCE COMPANY: Horizon NJ Health | United Healthcare Community Plan | Other

Insured's Name: _____ **Sex:** M or F **Patient ID #:** _____

Birthdate: _____ **Insured's Social Security #** _____

Do you have dual coverage? Yes_____ No_____

Other Insurance Company: _____ **Group #** _____ **Policy #** _____

Insured's Name: _____ **Sex:** M or F **Employer:** _____

Birthdate: _____ **Insured's Social Security #** _____

ASSIGNMENT OF BENEFITS

To be able to bill insurance companies and receive insurance checks payable on your account, we must have your signature. Signing this form, even if you have no insurance at this time, will allow us to immediately bill your insurance should you receive benefits while still in active treatment.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

I hereby authorize direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. (T. Roy Orthodontics, Dr. Tuhina Roy)

***Signature:** _____ **Date:** _____

APPEALS AUTHORIZATION

T. Roy Orthodontics will appeal insurance company decisions on your behalf when necessary. By signing below, you are authorizing us to submit appeals to your insurance company on your behalf.

***Signature:** _____ **Date:** _____

If you choose not to have us bill your insurance, you will be responsible for the entire balance of your account.

Troy ORTHODONTICS

Tuhina Roy,DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

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.

You may obtain a copy of our notice of Privacy Practices at any time by contacting:
Dr. Tuhina Roy, Troy Orthodontics, 159 E Main St., Little Falls, NJ 07424, (973) 785 -3035.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

You may refuse to sign this acknowledgement

Patient's Printed Name

Patient's Signature (Guardian's signature if patient is a minor)

Date

Please allow Troy Orthodontics to disclose/discuss my personal health information regarding my condition and treatment with the following individuals.

LIST NAMES BELOW:

1. _____

2. _____

3. _____

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)