

# Troy ORTHODONTICS

WELCOMES YOU!

**ADULT PATIENT INFORMATION:**

Date: \_\_\_\_\_

Sex: M or F

Date of Birth: \_\_\_\_\_

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

Address: \_\_\_\_\_  
Street City State Zip

Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

\*Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: (please circle one) Single Married Widowed Separated Divorced

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**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 your teeth?** \_\_\_\_\_

- Yes    No    Have you 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    Are you presently in any dental pain? \_\_\_\_\_
- Yes    No    Have you experienced any unfavorable reaction to dentistry? \_\_\_\_\_

**Do you have or have you had any of the following? (Please check all that apply to you)**

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

**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) \_\_\_\_\_

Have you ever had a CT scan or MRI of your head? \_\_\_\_\_

**Circle any of the medical conditions below that you have had or currently have.**

- |                              |                            |                          |                        |
|------------------------------|----------------------------|--------------------------|------------------------|
| 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 I will have a consultation and the results of this evaluation will be discussed with me. If my insurance covers this examination, a claim form will be sent to the insurance company. If further records are required (photographs, x-rays, and/or impressions) for a more complete review of treatment options, any additional fees will be discussed with me before these records are taken.

**\*Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**\*Reviewed by Doctor:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## 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.*



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)