ADULT ORTHODONTIC EXAM | Date

☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs. ☐ Dr. | Birthdate | Age

Street Address | Single ☐ Married ☐ Divorced ☐

City | Zip | Phone

Cell | email address

PersonResponsible for this Account | Surname | First | MI

Employed by | Phone | Occupation

Spouse / Significant Other Name

Employer | Phone #

Physician | Medical Insuance Provider ID/Group #

Dentist | Sent by

Do you have dental benefits? ☐ Yes ☐ No Ortho benefits? ☐ Yes ☐ No

MEDICAL HISTORY

Have you been diagnosed or treated for:

☐ Diabetes	☐ Artificial Joints	☐ Heart Trouble	☐ Bone Disorders
☐ Epilepsy	☐ Fainting	☐ Emotional	☐ Prolonged Bleeding
☐ Arthritis	☐ Rheumatic Fever	☐ Tuberculosis	☐ Hepatitis, AIDS, HIV (+)

Yes No

☐ ☐ Are you presently under physician's care ? For _____

☐ ☐ Are you taking any medications or drugs ? _____

☐ ☐ Have you ever had an unusual reaction/allergic reaction to medication/substances?

☐ ☐ Have you ever taken any oral bisphosphonate medication? How long? _____
For _____

☐ ☐ Have you ever had major surgery ? For _____

☐ ☐ Do you have a chronic problem with Kidney ☐ Heart ☐ Lung ☐ Liver ☐

☐ ☐ Are there any other medical problems we should be aware of ?
Describe: _____

DeLurgio & Blom ORTHODONTICS

DENTAL HISTORY

Date of last dental appointment _____

Yes No

☐ ☐ Do you breathe predominently through the mouth?
☐ ☐ Do you have any speech problems?
☐ ☐ Do you have any difficulty an/or pain when chewing, talking or using your jaws?
☐ ☐ Are you aware of noises in the jaw joints?
☐ ☐ Are you aware of any tooth grinding or clenching during the day or night?
☐ ☐ Do you have pain in or about the ears, temples or cheeks?
☐ ☐ Do you have a headache more than once a week?
☐ ☐ Are you bothered by chronic neck or shoulder pain?
☐ ☐ Does your bite feel uncomfortable or unusual?
☐ ☐ Do you chew on both sides of the mouth?
☐ ☐ Do your gums bleed on brushing or flossing?
☐ ☐ Have you ever had any severe head or face injuries?
If yes, when? _____
☐ ☐ Have you had previous orthodontic consultation or treatment?
If yes, when/where _____
_____
☐ ☐ Have your wisdom teeth been extracted? When _____
☐ ☐ How many times a month do you use dental floss? _____
☐ ☐ What concerns you most about braces?
☐ Appearance ☐ Cost ☐ How Long ☐ Pain ☐ Will it work
☐ Other _____
Is there anything you would like to add? _____
_____
☐ ☐ Do your anticipate a move or transfer in the near future?

REMINDERS

☐ ☐ I consent to receiving appointment reminders via
☐ email ☐ text (cell phone provider _____)

I have reviewed the above information and it is true and correct. If there are any later changes to this history record I will so inform this practice. I hereby authorize necessary credit information to be obtained by your office. I authorize the taking of diagnostic records for an initial diagnosis, if needed.

Date _____ *Signature* _____

There is an office charge of $ 122.00 for this examination. ☐ Pd. ☐ IB date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

To further communication, and to fulfill our responsibilities with law, we want you to understand how we protect and use your identification, payment, and medical information. The law, through HIPAA, more clearly defines your rights, and we want to make sure you understand your rights and our policies concerning this information. Your signature is an acknowledgment that you have received this notice. Thanking you in advance for your cooperation in this matter, and if you have any questions, please let us know.

I, (PRINT YOUR NAME) _____ have received a copy of this office's Notice of Privacy Practices.

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign ☐ Communications barriers prohibited obtaining the acknowledgment ☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)_____

ANDREA B. DELURGIO, D.D.S., M.S.D., INC.
HENDRIK F. BLOM D.D.S., INC.
SPECIALISTS IN ORTHODONTICS

DENTAL / ORTHODONTIC BENEFITS

TO OUR PATIENTS:

Welcome!

If you have Health or Dental / Orthodontic Benefits we will be happy to cooperate with you and your benefits carrier to see that you receive proper benefits from them. At the present time, our practice is not affiliated with or participating in any orthodontic benefit program, except for United Concordia and Delta Dental.

Patients who have orthodontic benefits should remember that professional services are rendered and charged to the patient, not their benefit (insurance) company. We cannot render services on the assumption that our charges *will be paid by an insurance company.*

If Delta Dental is your secondary benefits carrier, we will, as a **courtesy**, bill your primary carrier for you. If your primary benefits carrier pays your benefits, we will apply the benefit amount to your contract balance. However, you will still be responsible to make your contractual monthly payments.

If your benefit provider is other than Delta Dental or United Concordia, we will, as a **courtesy**, assist you in preparing necessary forms to expedite your benefit claims. The follow-up must be done by the covered individual. **We will request the benefit (insurance) company to pay your benefits directly to you.**

Some health insurance programs provide limited benefit coverage for orthodontics. Some provide no coverage. Patients are responsible to Drs. DeLurgio and Blom for their services.

Benefit Information

Patient's Name _____ Date of Birth m/d/y _____ Relation to the Covered Individual _____

Name of the Covered Individual (Insured) _____ Date of Birth m/d/y _____ Social Security Number _____

Address of the Covered Individual (Insured) _____

Employer of the Covered Individual (Insured) _____

Benefit Provider (Insurance Carrier) _____ Group Number _____

If the patient is covered by a ***second*** benefit policy, please complete the following for the second benefit policy:

Name of the Covered Individual (Insured) _____ Date of Birth m/d/y _____ Social Security Number _____

Address of the Covered Individual (Insured) _____

Employer of the Covered Individual (Insured) _____

Benefit Provider (Insurance Carrier) _____ Group Number _____

RELEASE:

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering benefit claims.

I understand that my dental care benefit provider may pay less than the actual bill for services. I understand I am financially responsible for my payment of services not paid, in whole or in part by my orthodontic benefit provider.

I attest to the accuracy of the information on this page. I have read and understand the above orthodontic benefit policy and agree to it.

Patient's Signature _____ Date _____

I hereby authorize payment of the Delta Dental benefits directly to the above named dentist. A copy of this authorization is valid.

Primary _____ Secondary _____
COVERED EMPLOYEE (OR AUTHORIZED PERSON) DATE COVERED EMPLOYEE (OR AUTHORIZED PERSON) DATE