ORTHODONTIC EXAM | Exam Date

PATIENT'S NAME | Birth Date

Street Address | Sex

City | Zip | Phone

Cell/Fax | email address

School | Grade

Mother's Name | Work Phone

☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. Soc. Sec. No.
☐ Married ☐ Divorced ☐ Widowed ☐ Remarried Birthdate

Father's Name | Work Phone

☐ Mr. ☐ Dr. Soc. Sec. No.
☐ Married ☐ Divorced ☐ Widowed ☐ Remarried Birthdate

Brother's Ages | Sister's Ages | Sent By | Dentist

Physician | Medical Insurance Provider

Legal Guardian | Relationship

Person(s) Responsible for this Account | Surname | First | Middle

Employed by | Occupation

Employer's Address | Phone

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

MEDICAL HISTORY

Has Patient been diagnosed or treated for any of the following:

☐ Diabetes	☐ Arthritis	☐ Rheumatic Fever	☐ Emotional
☐ Epilepsy	☐ Anemia	☐ Heart Trouble	☐ Endocrine
☐ Asthma	☐ Fainting	☐ Cerebral Palsy	☐ Bone Disorder
☐ Tonsils Removed	☐ Adenoids Removed	☐ Prolonged Bleeding	☐ Hepatitis
			☐ HIV (+), AIDS

Yes No

☐ ☐ Is Patient presently under physician's care ?
For _____

☐ ☐ Is Patient taking any pills, medications, or drugs ? _____

☐ ☐ Has Patient ever had an unusual reaction to medication ? _____

_____

☐ ☐ Is Patient allergic to anything ? _____

☐ ☐ Has Patient had any major surgery ? For _____

☐ ☐ Does Patient have a chronic problem with Kidney ☐ Heart ☐
Lung ☐ Liver ☐

Has the Patient reached puberty:

☐ ☐ Menstruated (girls) age _____

☐ ☐ Voice Change (boys) age _____

☐ ☐ Are there any other medical problems not mentioned above ?
Describe: _____

_____

DeLurgio & Blom ORTHODONTICS

DENTAL HISTORY

Date of last dental appointment _____

Yes No

☐ ☐ Does Patient presently suck his/her thumb or fingers?

☐ ☐ Does Patient breathe predominently through the mouth?

☐ ☐ Does the Patient have any speech problems?

☐ ☐ Does the Patient clench or grind teeth (at night) (day)?

☐ ☐ Does the Patient have pain or clicking upon closing the mouth?

☐ ☐ Has the Patient ever had any severe head or face injuries?
When? _____

☐ ☐ Have any teeth been injured or chipped due to accidents?
When? _____

☐ ☐ Does Patient have any noticeable difficulty in chewing or swallowing food?

☐ ☐ Has Patient been informed of any extra or missing teeth?

☐ ☐ Have any teeth (baby or permanent) been removed by extraction?
Why? _____

☐ ☐ Has a dentist ever placed a retainer or space maintainer?

☐ ☐ Has any member of the family had orthodontic treatment?
Who? _____

☐ ☐ Has patient had any previous orthodontic consultation or treatment? If yes, when? _____

☐ ☐ What concerns you and/or the patient most about braces?
☐ Appearance ☐ Cost ☐ How Long ☐ Pain ☐ Will it work
☐ Other _____

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 _____ 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