PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birthdate_____ Social Security # _____

School_____ Sports/Hobbies_____

Parent or guardian name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Previous Address (If less than 3 years) _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of any major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have you seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Are you pregnant? If so, how many weeks? _____
Yes No **Adolescents:** Has menstruation started? If so, at what age? _____

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 Hay Fever	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 you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Are you aware that some appointments will be during work hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, 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. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment, especially when retainers are not used. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Beeler to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Joshua J. Beeler, DDS, PC
928-537-7775

Our Financial Policy

Beeler Orthodontics
Live to smile. Love your smile.

Thank you for choosing us as your orthodontic health care provider. We are committed to your treatment being successful. Please understand that the payment for your bill is considered part of your orthodontic services. The following is a statement of our financial policy, which we request you to read and sign prior to any treatment. Please understand the financial contract you sign with Beeler Orthodontics also provides a Federal Truth and Lending document which details the financial terms to which you also agree. All patients are requested to complete our "patient information form" before seeing the Doctor.

Payment is due that the time of service: Unless prior arrangements are made, we accept cash, checks, Visa, Mastercard, Discover, American Express and Care Credit.

All fees for treatment must be paid in full at the completion of treatment. If a payment plan beyond this time is necessary, please ask for details.

Any account that becomes delinquent past 60 to 90 days will have a late fee of $10.00 and will be sent to a collection agency. You will be responsible for any collection fees, interest fees, or attorney fees associated with your account.

Regarding Insurance

We do not automatically accept assignment of insurance benefits as payment if full for orthodontic services provided. **The balance of your bill is your responsibility whether your insurance company pays you or not.** We cannot bill your insurance company unless you bring all needed insurance information. Your insurance policy is a contract between you and the company; we are not a party in the contract. Please be aware that some and perhaps all orthodontic services you receive may be non-covered services and may not be considered "reasonable and necessary" under the dental insurance plan. We will make a reasonable effort to work with insurance companies: however, once we have received either payment or denial of benefits the remainder of the balance is your responsibility and due within 90 days.

Usual and Customary Rates

Our practice is committed to providing the best treatment possible for our patients and our fees are in fact the usual and customary rates in our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of their usual and customary rates.

Responsible Party

The responsible party which signs the contract in order to start orthodontic treatment is responsible for the full payment at the time of service, for unaccompanied minors, the law requires that all non-emergency treatment be denied unless all treatment and charges have been pre-authorized by the parents or legal guardians. Payment is expected in full at the time of service with cash, check, any major credit card or Care Credit being acceptable means of payment.

Thank you for understanding our financial policy. Please let us know if you any questions or concerns.

I HAVE READ THE ABOVE FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THE POLICY:

X_____ DATE: _____

Signature of Patient/Responsible Party

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement**

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

For Program 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____