ORTHODONTIC
Medical and Dental History for Patients Under 18 Years of Age

Patient's Last Name:_____ **First name:**_____ **Middle initial:**_____ **Prefers to be called:**_____
Date of birth:_____ **Age:**_____ **Gender:**_____
Address:_____ **City:**_____ **State:**____ **Zip:**_____
Phone #: (home) _____ **(cell)**_____
School:_____ **Grade:**_____
Sports/hobbies/interests:_____
Brothers/sisters:_____ **Any siblings treated here?**_____

Parent or guardian's name:_____ **Additional Phone #:**_____
Email address:_____

Who is financially responsible for this patient's account? Last name_____**First**_____**Title**_____
Address (if different)_____
City_____**State**_____**Zip**_____**Phone #**_____
Employer:_____**Job title:**_____

Insurance information: Primary policy holder's: Last name_____**First**_____**MI**_____
Address (if different than patient)_____
City_____**State**_____**Zip**_____**Phone #**_____
SS#_____ **Date of birth**_____**Employed by**_____
Dental insurance company_____**Group #**_____
Secondary policy holder's: Last name_____**First**_____**MI**_____
Address:_____
City_____**State**_____**Zip**_____**Phone #**_____
SS#_____**Date of birth**_____**Employed by**_____
Dental insurance company_____**Group #**_____

How did you hear about our office?_____
General dentist's name_____**City**_____**State**_____
Date of patients last cleaning _____
Physician's name_____**City**_____**State**_____

For the following questions, please mark yes (Y) or no (N). These answers are for office records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation.

MEDICAL HISTORY Now or in the past has the patient had:

Y N Learning disabilities or need extra help with instructions?
Y N ADD or ADHD?
Y N Birth defects or hereditary problems?
Y N Was the patient adopted?
Y N Rheumatoid or arthritic conditions?
Y N Endocrine or thyroid problems?
Y N Diabetes?
Y N Cancer, tumor, radiation treatment, or chemotherapy?
Y N Acid reflux?
Y N Tuberculosis, polio, mononucleosis, or pneumonia?
Y N Problems of the immune system?
Y N HIV or AIDS?
Y N Hepatitis, jaundice, or liver problem?
Y N Seizures, epilepsy, fainting spells, or neurological problems?
Y N Mental health disturbance or depression?
Y N Vision, hearing, taste, or speech difficulties?
Y N History of eating disorder, anorexia or bulimia?
Y N Excessive bleeding or bruising tendency, anemia, or bleeding disorder?
Y N High or low blood pressure?
Y N Cardiovascular problems such as shortness of breath, angina, heart attack?
Y N Heart murmur, rheumatic fever, inborn heart defects, artificial heart valves?
Y N Allergies or asthma?
Y N Ear, nose, throat, tonsil or adenoid conditions?

(continued on other side)

Allergies or reactions to any of the following:
Y N Aspirin or Ibuprofen?
Y N Penicillin or other antibiotics?
Y N Codeine or other narcotics?
Y N Metals?
Y N Latex?
Y N Other substances:_____

Please list any medications, nutrient supplements, herbal medications, or non-prescription medicine the patient is currently taking:_____
Y N Does the patient currently have or ever had a substance abuse problem?
Y N Does the patient chew or smoke tobacco?
Y N Please list any operations or hospitalizations:_____
Y N Being treated by another health care professional? For _____

For Girls Only:
Y N Has menstruation begun? When?_____
Y N Is the patient pregnant?

DENTAL HISTORY Now or in the past, has the patient had:
Y N Extra or supernumerary teeth?
Y N Congenitally missing teeth or any permanent teeth removed?
Y N Early loss of baby teeth due to decay or trauma?
Y N Trauma or injury to baby or permanent teeth?
Y N Jaw fractures, cysts, or mouth infections?
Y N Periodontal or gum problems?
Y N Thumb or finger sucking habit? Until what age?_____
Y N Tongue thrusting?
Y N History of speech problems?
Y N Mouth breathing habit?
Y N Tooth grinding, jaw clenching, clicking or locking, or other problems of the TMJ?
Y N Any pain in jaw or face, ringing in the ears, or severe headaches?
Y N Frequent canker sores or cold sores?
Y N Any relative with similar tooth or jaw relationships?
Y N Any relative with jaw size imbalance?
Y N Ever had a prior orthodontic examination or treatment?

Y N Is there anything that you would like to discuss with the doctor in private?

I have read and understand the above questions. I will not hold Dr. Brian M. Bivens and/or Dental Specialty Group of Pinellas responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____Date:_____
(Parent/guardian)

Signed: _____Date:_____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES
Comments:_____
Signed: _____Date:_____
(Parent/guardian)

Signed: _____Date:_____
(Dental staff member)

DENTAL SPECIALTY GROUP OF PINELLAS
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SUITE C-EAST
PINELLAS PARK, FL
33781

Dr. Brian M. Bivens
Photographic Waiver and Consent

I hereby authorize and consent to the use of photographs of

_____ taken by Dr.Bivens.
Patient Name

I hereby grant permission to reproduce, publish, print, use and distribute copies of such photographs either in an official publication, or web site in the form of prints, slides or films for the use in connection with illustration of articles, brochures or lectures dealing with dental disorders. I specifically waive any claim for invasion personal privacy, which might occur due to the use of such pictures without my expressed consent in each instance.

_____ _____
Patient(if 18yrs or older) or Legal Guardian Date

OR

Patient or Legal Guardian refused waiver and consent.

_____ _____
Patient(if 18yrs or older) or Legal Guardian Date

Dental Specialty Group of Pinellas **Dr. Brian M. Bivens**
4326 Park Boulevard, Suite C-East **orthodontist**
Pinellas Park, FL 33781
www.dentalspecialtygroup.com

Appointment Policy

Our office strives to provide optimum treatment and convenience for our patients. However, Dr. Bivens is available only certain days so it is not always possible to schedule patients around school, work, or activities.

New patient exams and consultations will be scheduled during morning hours. Afternoons are reserved for patients in treatment.

This scheduling will allow us to give patients the proper time required for all procedures. Your cooperation is greatly appreciated.

Broken Appointment Policy

Failed appointments result in greater treatment time for the patient, as well as a lost appointment another patient may have wanted. If the failed appointment was after school, then this prime time is lost for you as well as all patients. A $25.00 fee will apply for broken appointments.

We understand that family emergencies or illnesses may occur while in orthodontic treatment. Our policy is as follows:

*2 broken appointments are allowed during the two years of orthodontic treatment.
*Appointments cancelled with a 24hour notice are appreciated and are not broken appointments.

Payment Policy

Our office system is set up to place only one person on a patient's account that is ultimately responsible for all payments.

If you are divorced or if you are collecting part of the money from another source to make the orthodontic payments, YOU (the named on the account) are the responsible party. YOU must collect all monies from your desired sources and make the payments on or before the due date. If you did not receive what you were expecting, YOU are still responsible!

Any account that is not paid by the due date will be assessed a fee of $25.00 after a 10 day grace period.

Signature below certifies I have read and understand the above policies.

X_____

Signature of patient (if 18years of age or older) or guardian

INSURANCE BENEFIT ACKNOWLEDGEMENT

Your insurance is a method for you to receive reimbursement for the fees you have paid. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on the contract you have with them, not with our office. It is your responsibility to pay deductible, coinsurance, and any other balances not paid by your insurance company.

In determining the amount of benefits payable, your insurance company may give consideration to an alternate procedure that may accomplish a professional satisfactory result. If an alternate benefit provision is applied to a procedure performed by your dentist and submitted to your insurance company as a claim, the amount of money you owe your dentist may be more than the amount specified on the Explanation of Benefits (EOB).

Estimates of coverage are not a guarantee as eligibility, policy provisions and possible charges from other offices affect payment. Your insurance company may not pay their full estimated portion. YOU ARE RESPONSIBLE FOR ALL TREATMENT CHARGES NOT PAID BY YOUR INSURANCE COMPANY.

I agree to pay the fees, including any deductible, co-insurance, and any other balances not paid by my insurance company, to Dental Specialty Group of Pinellas.

_____ _____

Signature of Patient/ Legal Guardian if patient is minor Date

_____

Patient's Name

Dental Specialty Group of Pinellas

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I have been given copy of this office's Notice of Privacy Practices to review and I am aware that the office has a copy of the Notice available to take with me if I request one.

_____
{Please Print Patient's Name}

_____
{Signature of Patient or Legal Guardian}

_____
{Date}

Dental Specialty Group of Pinellas may use or disclose protected health information for the purpose(s) of treatment, payment, collections, or health care operations. We may disclose your personal health care information to other dental and/or medical professionals relating to your treatment, payment, or health care. If you wish to authorize Dental Specialty Group of Pinellas to release your personal health care information to anyone other than for the reasons above, please list below.

1. _____
2. _____
3. _____

For Office Use Only

We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____
_____
_____