Geneseo Orthodontics & Pediatric Dentistry

Patient Health History

Name: _____ Birthdate: _____
Nickname: _____ Gender: M/F Phone #_____ Alt # _____
Address_____
City_____ State_____ Zip Code_____
Email_____

Parents/Guardian if underage 18yrs old:
_____ DOB _____ SSN#_____ Employer: _____
_____ DOB _____ SSN# _____ Employer: _____

Dentist Name: _____ Phone #_____

Please list the names of any family members currently in **our** practice:

Whom may we thank for referring you to our practice?

List any hobbies, sports or musical instruments played: _____

Dental Insurance and Financial Information:

Subscriber Name: _____ Birthdate: _____
Employer: _____ Subscriber ID#_____
Insurance Carrier: _____ Phone #: _____
Person financially responsible for treatment: _____
Relationship to patient: Self/mother/father/other: _____
Birthdate: _____ SS#: _____ Phone: _____
Address: _____

Dental History

Regular dental checkups: Y/N Frequency: _____

Previous orthodontic treatment Y/N If so, when: _____

What are your main orthodontic concerns? _____

List any medications patient is currently taking: _____

List any allergies including medications and/latex:

_____

Please select YES if patient has had any of the conditions listed below either now or in the past.

Speech problems Y/N
Grind/Clench teeth Y/N
Frequent Headaches Y/N
Injury to face/jaw/teeth/mouth Y/N
Discomfort from teeth/gums Y/N
Thumb/Finger sucking Y/N
Snoring/mouth breathing Y/N
Neck Pain Y/N
Tuberculosis/Lung Disease Y/N
Pneumonia Y/N
Cancer Y/N
Tonsils/Adenoids Removed Y/N

Diabetes Y/N
Blood Transfusion Y/N
Hemophilia Y/N
HIV/AIDS Y/N
Anemia Y/N Hepatitis Y/N
Kidney Disease Y/N
Liver Disease Y/N
Seizures/Epilepsy Y/N
Asthma Y/N
Heart Disease/Murmur/Stroke Y/N
Bone Disorder/Loss Y/N

Growth Problems Y/N Hospitalizations Y/N_____

Concerns that may affect patient's orthodontic/dental care_____

_____

Brush teeth daily Y/N Floss teeth daily Y/N

If patient is under 18yrs old:

If patient is a girl, has menstruation begun Y/N if yes when? _____

If patient is a boy, has their voice changed/have facial hair Y/N

(we ask this so we can determine where the child is in regard to growth)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient(s) Name(s): _____ DOB: _____

Please Read the Following Carefully:

Purpose of Consent: By singing this form, you will consent to our use and disclosure of you/your child's protected health information to carry out treatment, payment activities and healthcare operations.

[ ] I agree to receive appointment reminders by text message or email. I am aware that I can opt out an anytime.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, uses and disclosures we may make about your child's protected health information, and other important matters about your child's protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. You may obtain a copy of our Notice of Privacy Practices at any time, including any revisions of our Notice, by contacting:

Geneseo Orthodontics and Pediatric Dentistry PLLC- 70 Main Street Geneseo, NY 14454

Phone: 585-245-0050. Email info@geneseosmiles.com

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance of the consent before we received your revocation, and that we may decline to treat your child or continue treating your child if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing the Consent form, I am giving my consent to your use and disclosure of my/my child's protected health information to carry out treatment, payment activities, and healthcare operations.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Patient/Parent/Guardian Printed Name: _____ **Relationship to Patient** _____

Please list anyone (other parent, family members) to whom we can speak regarding the patient's care:

1.) _____ Relationship: _____

2.) _____ Relationship: _____

Financial Policy
Geneseo Orthodontics and Pediatric Dentistry
70 Main Street Geneseo, NY 14454
585-245-0050

Thank you for choosing Geneseo Orthodontics and Pediatric Dentistry! Our primary goal and responsibilities are to help our patients obtain high quality dental care in a relaxed, supportive, and fun environment. We present this Financial Policy to prevent misunderstandings and direct our time and energy towards this goal. Please read carefully and sign prior to treatment.

- Payment for all services provided by the practice is due in full at the time the services are rendered unless other arrangements have been made prior to your appointment.
- If you have private insurance, we will be happy to file for your visit. Your dental insurance is a contract between your employer and the insurance company. The percentage covered for each procedure is determined by how much your employer has paid for coverage. We will be happy to assist you in estimating your portion of the cost of treatment, but we would strongly recommend you become familiar with your insurance benefits ahead of time.
- We will collect your Estimated Patient Portion not covered by your insurance, including your deductible and percentage not covered.
- Some insurance carriers will not reimburse our office directly. In such instances, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.
- For your convenience, we accept cash, checks, and most major credit cards. Any returned checks will incur a $30 processing fee.
- A rebilling charge of $5 per month on the unpaid balance will be charged after 30 days. For accounts outstanding more than 60 days from treatment date, the $5 per month fee plus 2% interest per month will be charged.
- The parent or legal guardian who accompanies the minor at the appointment is responsible for payment of the Estimated Patient Portion.
- In the even that any outstanding balance must be referred to a collection agency or attorney for recovery, you will be fully responsible for all collection agency fees and attorney fees.
- If there are repeated broken appointments or canceled appointments with less than 24-hour notice, there may be a $35 charge applied to your account.

Please sign and date below to indicate that you have read and fully understand Geneseo Orthodontics and Pediatric Dentistry's Financial Policy.

Patient Name: _____

Signature: _____ Date: _____

Use of Photos and/or Video

Welcome to Geneseo Orthodontics & Pediatric Dentistry! We pride ourselves on being a fun, friendly and dynamic office. We frequently have contests and promotions that run in the office and on social media sites such as Facebook. This document outlines how you wish for us to handle the use of your name, photos and videos taken of you during your time as a patient with us. As you'll see below, there are a number of options for you to choose from. Please review this carefully and initial the areas that you feel comfortable giving us permission.
Thank you.

I consent to allow Geneseo Orthodontics & Pediatric Dentistry to use:

Intra-oral photos of my teeth only:	Yes/No
Photos of my face:	Yes/No
My name:	Yes/No
Videos of me:	Yes/No

Photos to be used for:

Research, training, lectures, or case studies:	Yes/No
Before and after photos:	Yes/No
Promotions or marking-website, Facebook, brochures:	Yes/No

Only as indicated above, I authorize use of my images and/or name without compensation to me. I hereby release the photographer and orthodontist at Geneseo Orthodontics & Pediatric Dentistry from all claims and liability to said photographs.

Patient Name: _____

Patient/Guardian Signature: _____Date: _____