SARATOGA SPRINGS ORTHODONTICS

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Please complete the following Patient Registration and Confidential Health History

1 Step — *Please Start Here.* *(Complete all that apply)*

Patient Name | Sex

Birth Date | Age *(years & months)* | Today's Date

Street Address

City | State | Zip Code

Home Phone # | Work Phone # | Cell or Pager # *(if applicable)*

Email Address | Dentist

Father's Name | D.O.B

Address | City | State | Zip

Home # | Work # | Cell #

Mother's Name | D.O.B

Address | City | State | Zip

Home # | Work # | Cell #

2 Step — *Emergency Contact Information*

Name of an individual you would like to contact in an emergency?

Address | City | State | Zip

Home # | Cell # | Ext #

Who Referred you to Saratoga Springs Orthodontics?

3 Step — *Insurance Information*

Primary

Subscriber Id #

Dental Insurance Company | Phone #

Street Address

City | State | Zip Code

Employer | Phone #

Insured Employee Name | D.O.B.

Date Employed | Insured Employee SS#

Secondary

Subscriber Id #

Dental Insurance Company | Phone #

Street Address

City | State | Zip Code

Employer | Phone #

Insured Employee Name | D.O.B.

Date Employed | Insured Employee SS#

4 Step — *Person Financially Responsible for Account*

Name | D.O.B.

Address | City | State | Zip

Home Phone # | Work Phone # | Ext #

SS # | Driver License #

Employer

Work Address | City | State | Zip

5 Step *Please read and answer the following questions Medical History Form*

1. Have you been under the care of a medical doctor during the past two years? ❑ Yes ❑ No
   Physician's Name _____ Type of Practice _____
   Address _____ Phone _____ Last Visited _____
2. Have you taken any medication or drugs during the past two years? ❑ Yes ❑ No
   Are you now taking any medication, drugs, or pills? ❑ Yes ❑ No
   If yes, please list: _____
3. Has the patient ever been hospitalized? ❑ Yes ❑ No If so, at what age and for what reason?
   Age: _____ Reason: _____
4. Has the patient had a history of any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Heart trouble or congenital heart lesions	❑	❑	Fainting or dizziness	❑	❑	Injuries to face, mouth or teeth
❑	❑	Asthma, allergies, or sinus infections	❑	❑	Diabetes	❑	❑	Missing or extra permanent teeth
❑	❑	Rheumatic fever	❑	❑	Tuberculosis	❑	❑	Clicking, popping or other problem with jaw
❑	❑	Bleeding disorders	❑	❑	Mononucleosis	❑	❑	Speech problems, speech or tongue therapy
❑	❑	Nervousness or hyperactivity	❑	❑	Hearing problems or ringing in the ears	❑	❑	Thumb or finger sucking
❑	❑	Hepatitis or liver involvement	❑	❑	Bone, collagen, or hormonal abnormalities	❑	❑	Tonsils and adenoids removed
❑	❑	Epilepsy	❑	❑	Grit or grind teeth (day or night)	❑	❑	Mouth breathing problems
❑	❑	Unfavorable reaction to any medication	❑	❑	Have you seen another orthodontist?	❑	❑	Other

5. Has patient reached puberty? _____
   Height _____ Weight _____
6. Reason for consultation _____

6 Step *Please read Office Policies and Federal Truth-in-Lending Statement*

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Financial responsibility on the part of each patient must be determined before treatment.

Patients who carry insurance that covers orthodontic care understand that they are still personally responsible for payments not met by their insurance company. This office will prepare the insurance forms for our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this office will not guarantee payment by an insurance company.

A service charge of 1.5% (18% per annum) on the unpaid balance will be assessed on all accounts exceeding ninety days from the due dates unless previously written financial arrangements are made. I understand further that the fee estimates given are valid for 12 months following the initial exam.

In consideration for the professional services rendered to me, or at my request for my minor child or ward, by the orthodontist, I agree to pay the agreed upon amount for said services, to said orthodontist. Money owed for services will be billed in a timely manner to patients.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and charges billed, payments made, and interest charges assessed, etc. to the orthodontists' collection agency or collection attorney should collection procedures as described become necessary. I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.

I authorize the orthodontist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted. I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined hereon. I agree to pay the remaining balance plus all collection/court costs and fees if a delinquent balance is placed with a collection agency or attorney.

7 Step *Please Sign Below*

_____ _____ _____

Signature of Patient or Guardian *Date* *Relationship to Patient*