STAR ORTHODONTICS
Steven Dickens, DDS, MS, PA

Patient Information

Full Name: _____ Prefers to be called: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ City: _____ State/Zip _____

Phone: _____ Birthdate: _____ SS: _____

Email: _____

If patient is a minor, give parent or guardian's name (Primary): _____

School: _____ Grade: _____

Additional family members: _____

1st Responsible Party Information

Full Name: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ City: _____ State/Zip _____

Phone: Home _____ Cell _____ Work _____

Marital status: ☐ Single ☐ Married Birthdate: _____ SSN: _____

Email: _____

Relationship to patient: _____

Employer: _____ Occupation: _____

2nd Responsible Party Information

Full Name: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ City: _____ State/Zip _____

Phone: Home _____ Cell _____ Work _____

Marital status: ☐ Single ☐ Married Birthdate: _____ SSN: _____

Email: _____

Relationship to patient: _____

Employer: _____ Occupation: _____

Do you have Orthodontic Insurance: ☐ Yes (complete section below) ☐ No (disregard lower section)

1st DENTAL/ORTHODONTIC INSURANCE (PRIMARY):

Insurance Company: _____

Address: _____ City: _____ State/Zip _____

Phone: _____ ID#: _____ Group#: _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's SSN: _____ Insured's Employer: _____

Insured's Email: _____

2nd DENTAL/ORTHODONTIC INSURANCE (SECONDARY):

Insurance Company: _____

Address: _____ City: _____ State/Zip _____

Phone: _____ ID#: _____ Group#: _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's SSN: _____ Insured's Employer: _____

Please take a photo of the front and back of your insurance card or bring it with you to the appointment. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

1. What is your primary concern: _____

2. What treatment option(s) interest you? ☐ Clear Aligners (ex. Invisalign) ☐ Clear/Metal Braces ☐ Retainers

3. How did you learn about our practice or whom may we thank for referring you?

☐ Google ☐ Dentist ☐ Social Media ☐ School or Sports banner ☐ Insurance Provider List

Friend / Family name: _____

Other : _____

4. Have you or your child been evaluated or had previous orthodontic treatment? ☐ Yes ☐ No If yes, how long ago? _____

5. General Dentist Information:

Dentist Name:_____ Dental visit in last 6 months ☐ Yes ☐ No

Please list any future dental procedures: _____

6. Check if you or your child have or has had any of the following:

☐ Anemia	☐ Asthma / COPD	☐ Abnormal bleeding	☐ Cancer Treatment	☐ Diabetes
☐ Epilepsy	☐ Fainting	☐ GERD / Acid Reflux	☐ Headaches / Migraines	☐ Heart problems
☐ Hepatitis	☐ High blood pressure	☐ HIV / AIDS	☐ Osteoporosis	☐ Pacemaker
☐ ADD / ADHD	☐ Stroke	☐ Tobacco use	☐ Autism	☐ Rheumatic Fever

Other / Details: _____

7. Indicate any history of (check all that apply); If checked "Yes" please explain.

☐ Thumb/finger sucker	☐ Tongue and/or swallowing problems	☐ Speech problems
☐ Loose teeth or broken Fillings	☐ Grinding and/or clenching of teeth	☐ Tonsils and adenoids removed
☐ Crowns/Bridges	☐ Root canals	☐ Mouth Breathing
☐ Snoring	☐ History of wearing a mouth guard at night	☐ Missing or extra permanent teeth
☐ Injury to face or teeth	☐ Mouth sores	☐ History of Periodontal treatment
☐ Clicking or popping jaw	☐ Jaw Pain	☐ Difficulty opening or closing jaw
☐ Cold, hot or sugar sensitivity	☐ Food collection between certain teeth	☐ Sensitivity when biting

Other / Details: _____

(Child) Has patient reached puberty? ☐ Yes ☐ No

8. Please list any allergies: _____

9. List Current medications and the correlating diagnosis:

Medication_____ Diagnosis _____

Any serious illnesses or operations? If yes, please describe.

_____

10. If treatment is recommended, how soon would you like to get started? ☐ ASAP ☐ Within the week ☐ Within the month

11. What payment option(s) would you like to review? ☐ No-Interest Monthly payment ☐ Payment in full w/discount ☐ HSA/FSA

12. Is there anything else you would like us to know before your visit? _____

To the best of my knowledge, the above questions have been accurately answered. I am aware it is my responsibility to inform this office of any changes to my medical, financial or insurance status. I understand that I am responsible (if 18 yrs. or older) for payment of services rendered and also responsible for any balance not covered by my insurance or my parent's insurance.

_____ _____

Signature of Patient and / or Parent/Guardian Date

Insurance Overview

There are many different agreements between insurance carriers and their subscribers, and each contract provides a different benefit. Many of the dental plans are based on a contracted fee schedule that is decided by your insurance carrier. However, orthodontic insurance generally differs from regular dental insurance in that each insured individual usually has a lifetime maximum benefit for orthodontic services. This benefit is paid at a percentage of the orthodontic fee on an 18-24 month payment schedule until the benefit maximum has been reached.

If you or your child are referred to your Dentist or a Specialist to have extractions or exposures done, whatever is paid towards that claim in most cases will be deducted from the orthodontic life time benefit. This will reduce the amount that we receive during the treatment process. This information is not released to us. You may have an insurance balance due towards the end of treatment. If this occurs we will transfer any unpaid insurance balance over to the patients account. The unpaid balance will be the responsibility of the "Responsible Party". Charges for lost or broken appliances are generally not covered by insurance and will be due at the impression appointment.

HOW OUR OFFICE ASSISTS YOU WITH INSURANCE

As a courtesy, we will call your insurance company to verify your eligibility and benefits. This does not guarantee payment of your benefit but only tells us that you are eligible today. If anything happens in the future to change your eligibility, your benefits may be reduced or denied. We are happy to accept the benefit payments from your insurance unless you have coverage that only pays the insured. We can only accept the primary insurance carrier if you have coverage with multiple carriers, we will file both plans on the initial visit, although follow-up is the responsibility of the insured.

IN NETWORK/OUT OF NETWORK

We are an In Network provider for Delta Dental only. We are Out of Network with all other insurance companies.

If you have coverage through anyone other than Delta Dental, it is your responsibility to verify the In Network benefits with them, as we can only confirm Out of Network coverage. It is your responsibility to choose a doctor in the appropriate network.

We do our best to provide accurate benefits information to you. The information we give you is based on the information released to us by the insurance carrier.

I UNDERSTAND THAT THIS IS ONLY AN ESTIMATE. IF PAYMENTS ARE EVER DENIED FOR ANY REASON OR INSURANCE BENEFITS TERMINATE OR DEDUCTABLE NOT MET OR INSURANCE CARRIER RELEASES INACCURATE BENEFIT INFORMATION, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ANY BALANCE NOT PAID BY THE INSURANCE CARRIER. THE UNPAID BALANCE WILL BE THE RESPONSIBILITY OF THE "RESPONSIBLE PARTY".

PLEASE INITIAL: _____

STAR
ORTHODONTICS
Steven Dickens, DDS, MS, PA

Authorization for Release of Information

Patient Name _____ Date of Birth _____

STARR & DICKENS ORTHODONTICS is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

ENTITY TO RECEIVE INFORMATION List each person that you approve to receive the information below.

PARENT/LEGAL GUARDIAN

Mom: _____ ☐ Financial ☐ Appointment/Treatment information

Dad: _____ ☐ Financial ☐ Appointment/Treatment information

(Please Print First & Last Name)

OTHER

Spouse: _____ ☐ Financial ☐ Appointment/Treatment information

Stepmom: _____ ☐ Financial ☐ Appointment/Treatment information

Stepdad: _____ ☐ Financial ☐ Appointment/Treatment information

Grandparent/Aunt/Uncle/Friend/ Guardian: **(circle)**

_____ ☐ Financial ☐ Appointment/Treatment information

(Please Print First & Last Name)

☐ Photo of patient received by patient or legal guardian ☐ May be posted in office

☐ Photo taken by staff (example: pre/post procedure ☐ May be posted on website

☐ Other ☐ May be posted on social media

Patient/Parent Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____/_____ Date_____

Signature of Patient or Personal Representative **Print name** of Patient or Personal Representative

Description of Personal Representative's Authority (Mother, Father, Legal Guardian) **please circle**

(ATTACH NECESSARY DOCUMENTATION IF LEGAL GUARDIAN)

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____

Patient Address _____

_____

Cell # _____ **Home #** _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature **Date**

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- **An emergency existed & a signature was not possible at the time**
- **The individual refused to sign**
- **A copy was mailed with a request for a signature by return mail**
- **Unable to communicate with the patient for the following reason:**

  _____

- **Other:** _____

  _____

Prepared by (staff) _____

Signature of (staff) _____

Date _____