STAR ORTHODONTICS
Steven Dickens, DDS, MS, PA
Christine Sirna Bode, DMD, MS

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

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Authorization for Release of Information

Patient Name _____ Date of Birth _____

STAR 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 _____

_____

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 _____

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Patient Code of Conduct

We are committed to providing a safe, respectful, and comfortable environment for all patients and staff. By working together with mutual respect and cooperation, we can achieve the best possible outcomes for your care.

This Code of Conduct outlines the behavior expected of all patients and explains the potential consequences of noncompliance.

Behavioral Expectations

As a patient, I agree to the following:

- I will address any concerns with the doctor or staff calmly and respectfully.
- I will refrain from any form of verbal or physical abuse, harassment, aggression, violence, or disruptive or intimidating behavior.
- I will respect the rights, safety, and privacy of other patients.
- I will not take photos or videos, or share images from inside the office or on social media, as this may violate another patient's privacy.
- I will not use recording devices (including smart glasses, recording assistants, or other wearable or voice-activated tools) within the office, as they may compromise patient privacy.
- I will treat the facility, equipment, furnishings, and technology with care. I will not tamper with, alter, or change settings on any office equipment, devices, or systems (including gaming stations, computers, or other technology).
- I will act in a manner that does not disrupt office operations or damage property.

Consequences of Noncompliance

If I fail to comply with this Code of Conduct, appropriate actions may be taken to ensure the safety and comfort of patients and staff. These actions may include, but are not limited to:

- Being asked to stop the behavior immediately
- Removal from the office
- Notification of law enforcement, if necessary
- Dismissal from the practice

I understand and agree to follow the above conditions during my visit to Star Orthodontics.

Patient Name: _____ **Date:** _____

Signature: _____

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Orthodontic Insurance Benefits Explanation Form

Patient Information:

- Name: _____
- Date of Birth: _____

Understanding Your Orthodontic Benefits:

1. **Lifetime Maximum Benefit**:

Orthodontic insurance typically includes a Lifetime maximum benefit. This is the total amount your insurance will pay towards orthodontic treatment over the lifetime of the insured individual.

- Example: If your policy has a$2000 lifetime maximum benefit, this is the maximum amount your insurance will pay for orthodontic services.

2. **Payment Schedule**:

Orthodontic benefits are usually paid out over the duration of the treatment rather than as a lump sum. This means we will receive periodic payments throughout the treatment process. Typically on a monthly, quarterly, semiannually or annually basis. This is based on the contract between your employer and insurance company.

- Example: For an 18-month treatment plan, your insurance may pay $111.11 per month if the total benefit is $2000

3. **Percentage of Coverage**:

Most insurance plans cover a percentage of the orthodontic fee, up to the maximum benefit.

4. **Deductibles**:

Some plans require a deductible to be met before benefits begin.

- Example: If your deductible is $100, you must pay this amount out-of-pocket before the insurance starts covering costs.

5. **Coordination of Benefits**:

If you have multiple insurance plans, the benefits may be coordinated. This means one plan will be considered primary and pay first, the secondary plan will be filed for you but we can only give

credit for the primary. Anything paid by the secondary will be applied to the back end of your contract.

6. **Exclusions and Limitations**:

   Certain procedures or conditions may not be covered by your orthodontic insurance.

   - Example: There may be an age limit for coverage

7. **Extractions and Other Procedures**:

   If you or your child need extractions or other dental procedures during orthodontic treatment, payments for these procedures may be deducted from the orthodontic lifetime benefit

   - Example: If $500 is paid for extractions, this amount may be subtracted from your orthodontic maximum benefit.

8. **Responsibilities**:

   - Updating Insurance information: If your insurance changes during treatment, it is your responsibility to provide the new insurance information to our office promptly.
   - Verifying Benefits: Ensure that your insurance policy is active and verify the coverage details with your insurance carrier.
   - Payment of Remaining Balance: If insurance benefits are exhausted or if claims are denied, the remaining balance will be your responsibility

9. **Contracted Fee Schedule**:

   Our office is not part of any contracted fee agreement between you and your insurance company. If any part of the benefit is refused due to the contracted fee schedule, you will be responsible for the remaining balance.

- Example: If your insurance denies part of the benefit because it exceeds the contracted fee, you must pay the difference.

Acknowledgment:

I understand the orthodontic insurance befits as explained above and agree to the terms and conditions. I acknowledge that I am responsible for any costs not covered by my insurance carrier. I authorized payment directly to the orthodontist for benefits otherwise payable to me.

Insured or Representative Signature: _____

Date: _____