Patient Information Date:_____

Patient's name: _____
Last First Middle

Address: _____
Street City Zip

Home Phone: _____ **Birthdate:** _____ **Social Security #:** _____

Whom may we thank for referring you to our office?_____

Responsible Party Information

Name:_____
Last First Middle

Residence: _____
Street City Zip

Mailing Address:_____
Street City Zip

How long at this address?_____ Home phone _____ Work phone _____

Previous Address (If less than 3 years) _____ Drivers' License:_____

Social Security # _____ Birthdate ___ _____ Relationship to Patient _____

Employer _____ Occupation_____ No. years employed_____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed_____

Social Security # _____ Birthdate _____Work Phone_____

Dental Insurance Information

Insured's Name_____ Insured's Social Security # _____

Insurance Company:_____ _____ Group No._____ Local No. _____

Insurance Co. Address: _____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insurance Company: _____ Group No._____ Local No. _____

Insurance Co. Address: _____ Phone No. _____

Emergency Information

Name of nearest relative not living with you _____

Complete address:_____
Street City Zip Phone

I understand that where appropriate, credit bureau reports may be obtained. Signature (Parent's signature if minor)

Thank you for choosing us to provide your dental health care. A statement of our financial Policies follows. Let us know if you have any questions

Consent for Services

As a condition of treatment in this office, financial arrangements must be made in advance. We depend upon reimbursement for the costs incurred in patient care. Financial responsibility on the part of each patient/guarantor must be determined before treatment begins. We have three options:

- **Payment is due at time of service**
- **We accept Cash, Checks, Visa/Mastercard or Discover. I understand that there will be a $35 fee for any check that is returned unpaid by my bank.**
- **We are members of Care Credit** (Ask your treatment coordinator for details. Or check on-line at carecredit.com/

Regarding Dental Insurance:

With the information provided, we do our best to calculate an estimate of what your dental benefit plan will pay on your behalf.

I understand that **this is an estimate** only **and that I am responsible for payment regardless of any insurance company's arbitrary determination of Usual and Customary Rates or Denial of any insurance claims. I agree to** pay my estimated share (co-payment and deductible) at the time of treatment and that after Dr. Leung receives payment from my insurance company my account will be reconciled and I will receive a bill or refund.

If I am covered by Delta Dental or Blue Shield, I understand that as a courtesy, all claims are submitted to my insurance company at time of service. Because Dr. Leung is not a participant, payments will be sent directly to the insured, thus I will make financial arrangements for the full amount of the treatment scheduled.

***Patients under the age of eighteen*:** I further understand that the adult accompanying a minor is responsible for payment of the services performed. Unaccompanied minors must to have a pre-arranged financial agreement before treatment.

***Patient Records*:** I [ ] do [ ] do not grant Dr. Leung and staff permission to use my dental image [video pictures] for educational purposes.

***Finance Charges*:** I am aware that service charge of **1.5%** per month (**18%** per annum, or a minimum of $2.00), will be added to all balances on all accounts over 60 days.

***Missed or Broken Appointments*:** I understand that my appointment time is reserved just for me and that there is no charge for rescheduled or cancelled appointment if I give at least **48hrs (2 working days)** notice to change my appointment. I realize that I will be billed $50 for a missed or an appointment cancelled with less than 2 business day's notice. **I REALIZE THAT I THAT WILL RECEIVE AN APPOINTMENT CARD OR A POST CARD WITH MY APPOINTMENT DATE & TIME & IT IS MY RESPONSIBILITY TO KEEP, OR CHANGE, MY APPOINTMENT BEFORE 2 BUSINESS DAYS OF ITS SCHEDULED TIME. I KNOW THAT I WILL NOT BE RECEIVING A CALL TO REMIND ME OF THE TIME.**

IF YOU MISS AN APPOINTMENT ON A SATURDAY, WITHOUT A 2 BUSINESS DAYS' NOTICE YOUR NEXT APPOINTMENT WILL BE DURING THE WEEK AT THE FIRST AVAILABLE APPOINTMENT. IF YOU MISS A TOTAL OF 3 SATURDAY APPOINTMENTS YOU LOSE SATURDAY PRIVILEGES AND YOUR FUTURE APPOINTMENTS WILL BE ON A WEEK DAY.

I am aware that the fee estimate listed for my dental care can only be extended for a period of six months from the date of my diagnostic examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the charges made for said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver or 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 reasonable attorney fees if suit be instituted hereunder. **I further agree to the assessment of a 41% collection fee to my balance due should my account become over 60 days delinquent.**

I have read the above conditions of treatment and payment and agree to their content. I authorized the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or my dental treatment.

_____ Date: _____ Relationship to Patient _____

Signature of Patient/Parent/ guardian

MEDICAL HISTORY~ Patient Name:_____

Physician_____ Date of Last Visit_____
Address_____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____
Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

Dentist: Dr._____ _____ Date of last visit _____

What concerns you most about your teeth? _____
Yes No Are you presently in any dental pain?_____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather?_____
Yes No Have you ever seen an orthodontist? If yes, who and when?_____
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result?_____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____
Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph.

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine an appropriate treatment. If there is any change in my medical or dental history, I will inform the orthodontist.

I authorize the insurance company on this form to pay the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that my diagnostic records and my name may be used for educational and promotional purposes. In addition, I authorize Dr. Nancy Leung to perform a complete orthodontic evaluation.

Signature:_____Date: _____