Town & Country ORTHODONTICS

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Houston, TX 77024
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www.townandcountryortho.com

1. Patient Information

First Name: | Middle Initials: | Last Name:

Nickname | Gender: ○ Female ○ Male | Date of Birth:

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widow | Home Address: | Apt./Unit #: | City:

State: | Zip Code: | Cell Phone: | Home Phone:

Email: | Hobbies:

2. Whom may we thank for referring you to our office?

○ Family/ Friends ○ Google ○ Facebook/ Instagram
○ Website ○ Dental Insurance ○ Dentist Referral

Name of Referrer/ Other

3. Responsible Party Information (Party Signing Contract):

First Name: | Middle Initials: | Last Name:

Date of Birth: | Relationship to Patient: ○ Mother ○ Father ○ Self ○ Step-Parent ○ Other | Email:

Street Address(If different from patient): | Apt./Unit #: | City: | State: | Zip Code:

Cell Phone(if different): | Home Phone: | Work Phone:

Employer: | Occupation:

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widow | Social Security No:

Spouse First Name: | Spouse Middle Initial: | Spouse Last Name:

Relationship to Patient: ○ Mother ○ Father ○ Step-Parent ○ Other

Email: | Employer:

Occupation:

NOTE: The following information is requested so that we may communicate properly with the people involved with your child's treatment

With whom does the patient live with? | Who may receive information about the treatment progress?

4. Do you have dental insurance?

○ Yes ○ No

5. Dental Insurance Information

Dental Insurance Company

Dental Insurance Phone Number:

Member ID / Policy #/ SSN

Group Number

Patient Relationship to Policy Holder
○ Self ○ Spouse ○ Child ○ Other

Policy Holder Name

Policy Holder Phone #

Policy Holder Date of Birth

Policy Holder Street Address

Policy Holder City

Policy Holder State

Policy Holder Zip Code

Employer:

Do you have secondary dental coverage?
○ Yes ○ No

6. Primary Insurance Card: Please take a photo of the back and front of your insurance card. Should treatment be recommended, providing your insurance card will allow us to share the portion of your orthodontic treatment fee covered by your plan.

PLEASE READ AND INITIAL THE FOLLOWING

7. FINANCIAL RESPONSIBILITY: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Town and Country Orthodontics and/or its affiliated entities for any charges not covered by dental benefits. It is my responsibility to notify Town and Country Orthodontics of any changes in my dental coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Town and Country Orthodontics and/or my dental insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, that I am accepting financial responsibility as explained above for all payment for dental services and/or supplies received.

ASSIGNMENT OF BENEFITS: I authorize direct remittance of payment of all insurance benefits to Town and Country Orthodontics for all covered dental services and supplies provided to me during all courses of treatment and care provided by Town and Country Orthodontics and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effects for so long as I am being treated or cared for by Town and Country Orthodontics, and will constitute a continuing authorization, maintained on file with Town and Country Orthodontics, which will authorize and allow for direct payment to Town and Country Orthodontics of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Town and Country Orthodontics.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any medical or dental information to my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related dental services and/or supplies provided to me by Town and Country Orthodontics. I also authorize the release of any medical and dental records to other dental entity and/or specialist. A copy of this authorization will be sent to my insurance carrier(s), or other dental entity, if requested. The original authorization will be kept by Town and Country Orthodontics.

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. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Domann and Dr. Orfanos to perform a complete orthodontic evaluation.

Sign Here

Signature

Date

8. Printed name

Relationship to Patient

Medical History

9. Physician Information:

Physician Name:

Date of Last Visit:

10. Please select Yes or No: (If yes, please fill in details)

	YES	NO
Is the patient currently taking any medication(s)?		
Is the patient allergic to any medication(s)?		
Is there history of any major Illness?		
Has the patient seen a physician in the last 12 months? If so, why?		
Has the patient had any operations? If so, please list.		
Has the patient ever been involved in a serious accident?		

If yes, please fill in details

11. Female Only:

	YES	NO
Has menstruation started?		
Is the patient pregnant?		

12. Select any of the medical conditions listed below that you have had or may currently have.

- ☐ Abnormal Bleeding/ Hemophilia
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone Disorders
- ☐ Diabetes
- ☐ Dizziness/ Fainting
- ☐ Epilepsy
- ☐ Heart Problems
- ☐ Gastrointestinal Disorders
- ☐ Hayfever
- ☐ Heart Murmur
- ☐ Hepatitis/ Liver Problems
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/ AIDS
- ☐ Kidney Problems
- ☐ Nervous Disorders
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Radiation/ Chemotherapy
- ☐ Rheumatic Fever
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumor/ Cancer
- ☐ NONE

13. Are there any other medical conditions NOT listed on this form we need to be aware of?

Dental History

14. General Dentist Information:

General Dentist Name: Date of Last Visit:

15. What concerns you most about your teeth?

_____

_____

_____

_____

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

- ☐ Self-Conscious of Teeth
- ☐ Injury to face, mouth, or teeth
- ☐ Temperature Sensitivity
- ☐ Thumb/Tongue Habit
- ☐ Sleep Apnea
- ☐ Tongue and/or swallowing problems
- ☐ Unfavorable Reaction to Dentistry
- ☐ Missing, lost or chipped any teeth
- ☐ Bleeding gums when brushing
- ☐ Speech Problems/ Speech Therapy
- ☐ Clench/Grind teeth during the day
- ☐ NONE
- ☐ Dental Pain
- ☐ Permanent teeth extractions
- ☐ Grinding and/or clenching of teeth
- ☐ Mouth Breathing
- ☐ "Tension" Headaches

Other/Details:

_____

17. Have we treated any family member?

_____

What is your attitude toward receiving orthodontic treatment?

_____

Are you aware that some appointments will be during school/work hours?

_____

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 status. I permit to perform necessary orthodontic records, and I am aware you may use these records for in-office education.

_____ _____

Signature Date

18. Please Print Name and Relationship to Patient

_____