Van Westen orthodontics

We would like to welcome you and your family to
Van Westen orthodontics

Where Smiles Come Together for a lifetime

Child Patient Account Registration

Date ___/___/____

In an effort to provide the best service possible, we ask you to fill out this account registration form. We provide the highest level of confidentiality with respect to the collection and disclosure of all patient's personal information that is provided to us.

Patient's name: _____ Nickname:_____
First Middle Last Name

Address:_____
Street City State Zip

Home phone: _____ Birthdate:_____ Age:____ Gender: F__ M __

School: _____School City: _____Grade: _____

Hobbies: _____

Other family members seen by our office _____

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

Patient lives with

Both Parents___ Mother___ Father___ Guardian___ Other___Relation to patient_____

Party Responsible for Financial Account

Both Parents___ Mother___ Father___ Guardian___ Other___Relation to patient_____

Father's name:_____
First Middle Last Name

Address: _____
Street City State Zip

How long at this address?_____ email:_____

Home phone: _____ Cell phone: _____ Work phone:_____

Birthdate: _____ Marital status:_____ SSN: _____

Employer:_____Occupation: _____How long employed? _____

Mother's name:_____
First Middle Last Name

Address: _____
Street City State Zip

How long at this address?_____ email:_____

Home phone: _____ Cell phone: _____ Work phone:_____

Birthdate: _____ Marital status:_____ SSN: _____

Employer:_____Occupation: _____How long employed? _____

If "Guardian" or "Other", please complete information below:

Name:_____
First Middle Last Name

Address: _____
Street City State Zip

How long at this address?_____ email:_____

Home phone: _____ Cell phone: _____ Work phone:_____

Birthdate: _____ Marital status:_____ SSN: _____

Employer:_____Occupation: _____How long employed? _____

Insurance Information

INSURANCE BENEFITS

Dental insurance is meant to be an aid in receiving dental care by reducing your costs. Most insurance companies have a lifetime orthodontic benefit separate from regular dental coverage. As a courtesy, we will submit claims on your behalf.

Our office will obtain a pre-treatment estimate. This pre-treatment estimate was quoted by your insurance company and is assumed to be accurate. However, this is not always the case. The actual reimbursement can only be known after the service has been provided and the charges are submitted to your insurance.

If insurance coverage changes or terminates during the course of treatment, any remaining balance will become the obligation of the person financially responsible for the account or our office will transfer the balance to your new insurance carrier.

Primary Dental Insurance Information

Policy Holder's name: _____ Phone#_____
First Middle Last Name

Policy Holder's Address:_____
Street City State Zip

Birthdate: _____ SSN:_____ Employer: _____

Relation to patient: _____ Group #: _____ ID#:_____

Insurance Company: _____Provider Services Phone#:_____

Insurance Address: _____
Street/PO Box City State Zip

Secondary Dental Insurance Information

Policy Holder's name: _____ Phone#_____
First Middle Last Name

Policy Holder's Address:_____
Street City State Zip

Birthdate: _____ SSN:_____ Employer: _____

Relation to patient: _____ Group #: _____ ID#:_____

Insurance Company: _____Provider Services Phone#:_____

Insurance Address: _____
Street/PO Box City State Zip

Medical History

Physician's name/Medical Group_____Phone #_____

Is child under a physician's care? N____Y____For what reason?_____

Last visit:_____

Is child taking any medications? N____Y____ For what reason?_____

List all prescribed AND over-the-counter medications taken:_____

_____

Is antibiotic premedication required before dental procedures? N___Y___

Does child have any allergies? N____Y____ If so, describe_____

Have adenoids or tonsils been removed? N____Y____If so, at what age?_____

Has puberty been attained? N____Y____ If so, at what age?_____

Does child smoke or chew? N____Y____If so, what products?_____

Are there any other medical/behavioral/learning challenges that you feel we should be aware of? Special needs? ADHD? Physical restrictions? Auditory or visual challenges? Autism?

If so, please describe:_____

Women - Is child pregnant or thinks she may be pregnant? N____Y____

Mark **YES** or **NO** for any of the medical conditions below that child has had or currently have:

N____Y____ Anxiety/Depression
N____Y____ Arthritis
N____Y____ Asthma
N____Y____ Abnormal/Prolonged bleeding/Hemophilia
N____Y____ Bone disorder/Osteoporosis
N____Y____ Cancer/Radiation/Chemotherapy
N____Y____ Congenital Heart Defect/Heart Murmur
N____Y____ Diabetes
N____Y____ Endocrine/Hormone/Thyroid disorder
N____Y____ Eating disorder
N____Y____ Fainting spells/Seizures/Epilepsy
N____Y____ GI disorder/Stomach
N____Y____ Vision, hearing, speech problems
N____Y____ Herpes (oral)
N____Y____ Heart Surgery
N____Y____ Heart Disease
N____Y____ High/Low blood pressure
N____Y____ Immune disorder/Lupus
N____Y____ Joint replacement
N____Y____ Kidney disease
N____Y____ Lung disease
N____Y____ Liver disease/Hepatitis
N____Y____ Mitral Valve Prolapse
N____Y____ Tuberculosis
N____Y____ HIV/AIDS

Please list any other medical conditions or surgeries:_____

Dental History

Dentist's name/Dental Group _____Phone #_____

Does child have regular dental check-ups every 6 months? N____Y____ Last visit:_____

What is child's oral hygiene regimen presently?_____

Is child in any dental pain? N____Y____If so, describe_____

Reason for Orthodontic Consultation_____

Have you consulted or had treatment by another orthodontist? N____Y____

If so, Who?_____ When? _____

Is child anxious about receiving orthodontic treatment? N____Y____

Mark **YES** or **NO** for any of the dental conditions below that <u>child has had</u> or <u>currently have</u>:

N____Y____ Persistent thumb / finger / tongue thrust habit

N____Y____ Grinding or clenching of teeth

N____Y____ Mouth breather (oral respiration)

N____Y____ Frequent canker sores or cold sores

N____Y____ Tooth sensitivity (hot, cold, sweets, pressure)

N____Y____ Tooth color changes
If so, describe_____

N____Y____ Loss or removal of permanent teeth
If so, describe_____

N____Y____ Congenitally missing teeth / extra teeth
If so, describe_____

N____Y____ Replacement of missing teeth (bridge, implant, removable appliance)
If so, describe_____

N____Y____ Periodontal disease (gum and bone supporting disease)
was treatment recommended?_____When?_____ By whom?_____
was treatment performed?_____When?_____ With whom?_____

N____Y____ Individual or family history of head and neck cysts
If so, describe_____

N____Y____ Individual or family history of excessive growth of the lower jaw
If so, describe_____

N____Y____ Dental or facial trauma (teeth, jaw, head injuries)
when_____ treatment needed_____

N____Y____ Temporomandibular Joint Dysfunction (TMD) - pain, clicking, locking, headaches
was treatment recommended?_____When?_____ By whom?_____
was treatment performed?_____When?_____ With whom?_____

RELEASE OF ACCOUNT INFORMATION

1- PHI and Notice of Privacy Practices

Van Westen orthodontics is required by law to maintain the privacy of Protected Health Information or PHI, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of PHI.

This notice is called **"Notice of Privacy Practices"**, which states how we may use and/or disclose your health information and we are required to provide you with a copy of it unless you elect otherwise.

Please check below which option you would like to take regarding the receipt of the Notice:

____I have been presented with and elect to NOT receive the **"Notice of Privacy Practices"**

OR

____I confirm that I have received and reviewed the "**Notice of Privacy Practices"**

2- Release of Medical and Dental Information

I have answered the above medical and dental questions in an accurate manner. I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I authorize Luciana Van Westen, DDS, MS to perform a complete orthodontic evaluation.

You have my permission to further inquire the respective care providers listed above and to release medical, dental and personal information, regarding the condition, diagnosis or proposed treatment

I will notify Van Westen orthodontics of any changes in my child's medical and dental health status, including changes in medications and allergies.

3- Financial and Insurance Information

I authorize my insurance carrier or any other third-party administrator to pay for the dental/ orthodontic insurance benefits otherwise due and payable to me directly to:

Van Westen orthodontics LLC or Luciana Van Westen, DDS, MS.

I understand that I am responsible for all costs of orthodontic treatment that are not covered by my dental/orthodontic insurance.

By signing this document, I confirm that I have read, understood, and agree to the information discussed above.

_____
Parent or Guardian (PRINT)

_____ Today's date___/___/_____
Patient / Parent or Guardian (SIGNATURE)