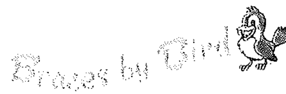


New Patient Information: Child

Patient Information

Patient's Last Name:

Patient's First Name and Middle Initial:

Patient's Nickname:

Patient's Gender:

Patient's Birthdate:

Patient's Street Address:

Patient's City: Patient's State: Patient's Postal Code (Zip code):

Patient's General Dentist:

Date of Last Cleaning/Check Up at General Dentist's Office:

Patient's School

How did you learn about Braces by Bird and/or whom may we thank for referring you?

What concerns you most about your teeth?

If you are here for your child, are you interested in orthodontic treatment for yourself?

Billing Party Information (Person financially responsible)

Billing Party's Last Name:

Billing Party's First Name:

Billing Party's Gender:

Billing Party's Birthdate:

Billing Party's Street Address:

Billing Party's City: Billing Party's State: Billing Party's Postal Code (Zip code):

Billing Party's Home Phone:

Billing Party's Cell Phone:

Billing Party's Work Phone:

Billing Party's Social Security #

Billing Party's Marital Status

What is the billing party's relationship to the patient?

Self Mother Father

Aunt Uncle Grandmother

Grandfather Guardian

Billing Party's email address:

Billing Party's employer:

Dental Insurance Information

If you have dental insurance, please provide the following information so we can verify your benefits before your scheduled appointment.

Primary Insurance Policy Coverage:

Policy Holder's Name (Last Name, First Name):

Policy Holder's Date of Birth:

Policy Holder's Social Security #:

Insurance Company Name:

Insurance Company Phone Number (from the back of the card):

Subscriber ID #:

Group or Account #:

Secondary Insurance Policy Coverage (if applicable):

Secondary Policy Holder's Name (Last Name, First Name):

Secondary Policy Holder's Date of Birth:

Secondary Policy Holder's Social Security #:

Secondary Insurance Company Name:

Secondary Insurance Company Phone Number:

Secondary Policy ID #:

Secondary Group #:

Medical History

Physician's Name (Last Name, First Name)

Physician's Phone Number:

Date of Last Visit:

Has the Patient ever had any of the following medical concerns? (Check all that apply)

No Medical Concern	Anemia	Artificial Bones/Joints/Valves
Asthma/Arthritis	Blood Transfusion	Cancer/Chemotherapy
Congenital Heart Defects	Diabetes	Difficulty Breathing
Drug Abuse	Emphysema	Epilepsy/Seizures/Fainting
Fever Blisters/Herpes	Handicaps/Disabilities	Hearing Impairment
Heart Murmur	Heart Surgery	Hemophilia
Hepatitis	High/Low Blood Pressure	HIV+/AIDS
Hospitalization for Any Reason	Kidney Problems	Mitral Valve Prolapse
Psychiatric Problems	Radiation Treatment	Rheumatic / Scarlet Fever
Sever/Frequent Headaches	Shingles	Sinus Problems
Tuberculosis	Ulcers/Colitis	Venereal Disease
	Abnormal Bleeding	Sickle Cell Disease / Traits

Is the patient allergic to any of the following? (Check all that apply)

No allergies	Aspirin	Any Metals/Plastics
Codeine	Dental Anesthetics	Erythromycin
Latex	Penicillin	Tetracycline

Other (Please indicate in the entry below)

Other Allergies:

Is the patient currently taking hormone replacement medication? Yes No

Please list any medications currently being taken:

Does the patient need to take antibiotics prior to dental treatment? Yes No

Dental History

Please check all of the following that apply:

None of the following	Suck thumb and/or fingers	Tongue thrusting
Mouth breathing	Speech problems	Teeth grinding
Pain and/or clicking when opening mouth	Severe head or face injuries	Teeth chipped due to accidents
Missing permanent teeth	Extra teeth	

Have you ever had any previous orthodontic consultation or treatment? Yes No

Does anyone in family have a similar dental condition? Yes No

Emergency Contact Information

In case of emergency, please provide the mane of the nearest relative:

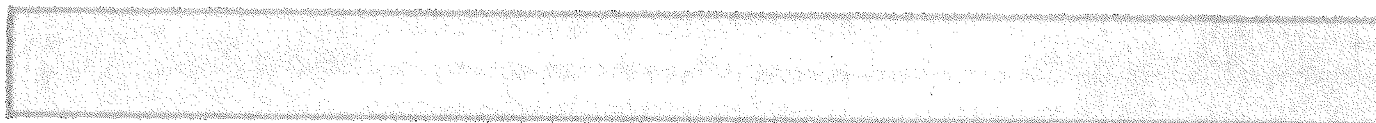
Emergency Contact's Name (Last Name, First Name):

Emergency Contact's relationship to patient:

Emergency Contact's Phone #:

Signature:

Date



Suzanne E. Bird, DDS, MS, PA

Authorization for Release of Information – Compound Release

Name of Patient ______________________________ Date of Birth ____________________

BRACES BY BIRD is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Spouse (provide name and phone number) ______________________________	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) ______________________________	☐ Financial ☐ Medical
☐ Other (provide name and phone number) ______________________________ ______________________________	☐ Financial ☐ Medical
☐ Email communication – Provide email address* ______________________________ ☐ Voice Mail *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

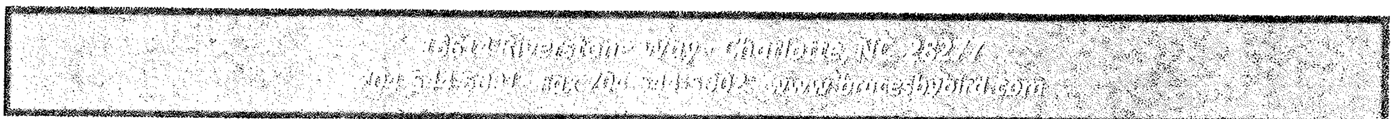
Patient Rights:

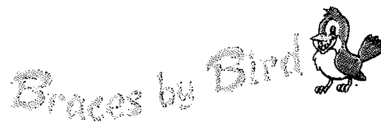
- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where information has already been disclosed but will be effective going forward.
- Information used 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

______________________________ Date ____________________

Signature of Patient or Legal Guardian





Acknowledgement of Receipt of Notice of Privacy Practice

Patient Name & Address: ______________________________

____

____

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

______________________________ ______________________________

Responsible Party (Signature) Date

For Office Use Only

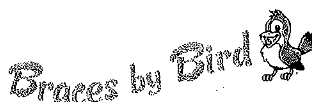
We are unable to obtain a written acknowledgement of receipt of Notice of Privacy Practices because:

- ☐ 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 parent for the following reason: ______________________________

____

______________________________ ______________________________

Prepared by (Signature)



Suzanne E. Bird, DDS, MS, PA

Patient Name: ______________________ **DOB:** ______________

Patient Policies Consent

1. A proposed treatment plan will be presented upon the start of treatment. Dr. Bird will use her professional judgement with regards to the type of orthodontic treatment recommended. If you have a preference to the type of material used (traditional brackets, clarity brackets, or Invisalign), please verbalize it prior to the orthodontic start appointment. All reasonable efforts will be made to meet your request.
2. Please be aware that occasionally, treatment plans may change unexpectedly. You (the responsible party) will be responsible for the difference in fee, if there is one.
3. We allow parent presence during consultation appointments and regular orthodontic adjustments. At appointments for the application of orthodontic appliances and braces, Dr. Bird and her associates request that your child comes back to the treatment area alone, as this enables us to provide full attention to them and allows us to work without distraction. Most children tolerate treatment better without their parent present.
4. Certain typed of appointments require particular lengths of time and attention, therefore are scheduled at specific times of the day.

Your signature indicates that you have read, understand and agree to Dr. Bird and her associate's policies above.

______________________ ______________

Responsible Party (Signature) *Date*

Financial Consent

1. Payment terms must be agreed upon at the time initial service is rendered. We accept cash, Care Credit, Visa, MasterCard, Discover, and American Express payments. We gladly accept checks but will need the license number and state of the person issuing the check. A $35 fee will be issued by your bank for insufficient funds.
2. You, the responsible party of the patient, are responsible for 100% of the treatment fees. We do accept insurance assignment as a courtesy to our patients. For all proposed treatment, we estimate your portion and the insurance company's proposed benefits. We cannot guarantee either eligibility or coverage, but we will use this estimate as a rough guideline until final payment has been received from your insurance company. At that time, we will reconcile the amount and bill or refund you any difference. We are not responsible for insurance claim disputes or negotiation of disputed claims.
3. In the event your account becomes more than 90 (ninety) days past due, it will be referred to our collections department to ensure account performance and will accrue interest at the maximum allowable legal rate. You will be responsible for all fees associated with the collection activities, attorney's fees, and court costs.

Your signature indicates that you have read, understand and agree to Dr. Bird and her associate's policies above.

______________________ ______________

Responsible Party (Signature) *Date*

Patient Information

1. 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 describe 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.
2. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
3. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned to signing. This authorization shall be in effect until revoked by the patient.

______________________ ______________

Responsible Party (Signature) *Date*

INFORMED CONSENT FOR VIDEO RECORDING FOR SAFETY, SECURITY, TREATMENT PURPOSES AND IMPROVED PATIENT CARE

Name of Patient (print): ______________________ Date of Birth: ______________

Address: ____

City, State, Zip: ______________________ Phone: ______________

It is the policy of **Braces by Bird ("BBB")** to provide the highest quality dental and orthodontic services to our patients, prospective patients and their family members. To ensure a high level of care, as well as the safety and security of our patients, the premises of BBB are under continual video surveillance. I/We acknowledge and consent voluntarily that the video surveillance may be monitored and/or recorded for safety, security, treatment purposes and improved patient care.

______________________________ ______________
Signature of Patient or Legal Representative Date

______________________________ ______________
Witness Date