MKL ORTHODONTISTS
Diplomates of American Board of Orthodontics

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Patient Responsibilities and Insurance Information

Patient Name_____

We look forward to providing you and/or your children with the best orthodontic treatment available. We realize that in order to achieve outstanding results it requires a team effort between our doctors, staff, and the patient. In many cases the patient's parents/guardians play a very important role as well.

Appointment Scheduling:

When scheduling orthodontic appointments, it is our intent to make every effort possible to accommodate your schedule. Due to the nature of our services, many of our patients are of school age. Early morning and late afternoon appointments are available, but limited. These times are scheduled on a first come first served basis. In order to accommodate as many patients as possible during these hours we try to limit longer appointments to other times throughout the day. We appreciate your help and understanding in upholding this policy.

Insurance and Payment:

Before the start of treatment you will be presented with an orthodontic diagnosis, a detailed treatment plan, treatment time estimates, treatment fees, and payment options. Ultimately you, the receiver of orthodontic services, are responsible for payment of services provided. Should your financial account become delinquent we have the right to request payment in full or discontinue treatment at our discretion.

We will work with you and your insurance carrier to ensure you get the maximum orthodontic benefits available towards your treatment. Please provide our business office with your insurance information so we can help you determine the amount of benefits available and how those benefits will be disbursed. Your orthodontic benefits will be sent directly to you in your name. We will submit all pertinent information to your insurance carrier in order for you to receive your full benefits. Orthodontic insurance may be different than your general dental benefits where payments go directly to the dentist office.

Method of Payment:

We accept cash, Visa, MasterCard, Discover, American Express and check or money order payable to *MKL Orthodontist*s. Once you have been presented with your treatment plan and fee you will have payment plan options with our office or with *Lending Club Financing.*

I acknowledge that I have read and understand the above information and I give MKL Orthodontists permission to submit to my insurance carrier any/all information that they deem necessary.

Date: _____ Patient signature: _____

(Parent or guardian if patient is a minor)

DR _____

WELCOME TO OUR OFFICE

TODAY'S DATE_____

PATIENT'S NAME MALE / FEMALE		BIRTHDATE
ADDRESS (ST.)		CITY, STATE, ZIP
HOME PHONE	CELL PH. #/ CARRIER	PATIENT'S S.S# (IF ADULT)
PLACE OF EMPLOYMENT (IF ADULT)	WORK PHONE	SCHOOL NAME
SPECIAL INTERESTS	WHAT (IF ANY) MUSICAL INSTRUMENT IS PLAYED?	

IF MINOR, COMPLETE FOLLOWING:

FATHER'S NAME		ADDRESS (ST.)
HOME PHONE	CELL PH. #/ CARRIER	CITY, STATE, ZIP
OCCUPATION		WHERE EMPLOYED
WORK PHONE		FATHER'S S.S.#
MOTHER'S NAME MRS. MS.		ADDRESS (ST.)
HOME PHONE	CELL PH. #/ CARRIER	CITY, STATE, ZIP
OCCUPATION		WHERE EMPLOYED
WORK PHONE		MOTHER'S S.S.#

WHO WOULD BE RESPONSIBLE FOR THE ACCOUNT? **ADDRESS (ST.)**

NAME OF INSURANCE CO. IF ORTHODONTIC COVERAGE IS AVAILABLE

NAME OF INSURED **INSURED D.O.B.** **SOCIAL SECURITY NUMBER**

WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT CONFIRMATION BY:
PHONE EMAIL OR TEXT

HOME E-MAIL ADDRESS:

PRIMARY EMAIL (PATIENT/MOTHER/FATHER):

SECONDARY EMAIL (PATIENT/MOTHER/FATHER):

SIGNATURE OF PATIENT OR PARENT **DATE**

WHO RECOMMENDED OUR OFFICE TO YOU?

HAVE WE TREATED ANY OF YOUR RELATIVES? YES ❑ NO ❑ THEIR NAMES

PLEASE WRITE THE NAMES (AGES) OF OTHER CHILDREN IN YOUR FAMILY ( )

( ) ( ) ( )

WHO IS THE PATIENT'S DENTIST

WHAT ARE THE DENTIST'S CONCERNS ABOUT YOUR TEETH?

HOW DO YOU FEEL ABOUT BRACES?

I'M INTERESTED IN ❑ BRACES ❑ INVISALIGN ❑ WHATEVER WORKS BEST

TMJ, JAW OR HEAD PAIN	YES	NO
DO YOU HAVE FREQUENT PAIN IN JAWS OR JAW JOINTS?		
DO YOU HAVE FREQUENT HEADACHES?		
HAS ANY DOCTOR EVER TOLD YOU THAT, YOU MIGHT HAVE A TMJ PROBLEM?		
DO YOU HAVE A CLICKING, CRACKING, POPPING OR GRATING SOUND IN YOUR JAW JOINTS?		
ARE THE JAW (OR CHEWING) MUSCLES FREQUENTLY SORE?		
DO YOU FREQUENTLY EXPERIENCE RINGING IN THE EARS OR DIZZINESS?		
DO YOU FREQUENTLY EXPERIENCE TIGHTNESS, SPASMS OR PAIN IN THE MUSCLES OF SHOULDERS/BACK/NECK?		

PLEASE GIVE A BRIEF SUMMARY OF (a) Who has treated you (b) For how long (c) What was done & results

When answered by someone other than patient, "You" refer to patient

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD:

	YES	NO		YES	NO
HEPATITIS/LIVER PROBLEMS			BIRTH DEFECTS		
ALLERGY TO PENICILLIN			MEASLES		
ALLERGY TO LATEX			MUMPS		
ALLERGY TO NICKEL/METALS			CHICKEN POX		
DIABETES			SPEECH PROBLEMS		
EPILEPSY/SEIZURES			SWALLOWING PROBLEMS		
ASTHMA			FAINTING		
BREATHING PROBLEMS			EYE DISORDER		
HAY FEVER/ALLERGIES			GLASSES/CONTACTS		
SINUS PROBLEMS			GLAUCOMA		
HEART CONDITION/MURMUR			ULCERS/COLITIS		
BLEEDING PROBLEMS/ANEMIA			HIV/AIDS		
OSTEOPOROSIS			PHYSICAL HANDICAP		
ORAL OR IV BIOPHOSPHONATE TREATMENT			MENTAL HANDICAP		
KIDNEY PROBLEMS			TUBERCULOSIS		
REACTION TO DRUGS			HIGH BLOOD PRESSURE		
REACTION TO ANESTHETIC			RHEUMATIC FEVER		
NERVE PROBLEMS			EATING DISORDER		
BACK OR NECK PROBLEMS			ADD/ADHD		
MAJOR SURGERY			TONSILS/ADENOIDS REMOVED		
			TAKING MEDICATIONS NOW		

ANY COMMENTS ON ANY OF THE ABOVE OR ON OTHER HEALTH MATTERS YOU WOULD LIKE US TO KNOW

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? YES ❑ NO ❑

COMMENTS:

HAVE YOU HAD ANY PAST HOSPITALIZATIONS? YES ❑ NO ❑

COMMENTS:

DENTAL HISTORY

DO YOU HAVE OR HAVE YOU HAD	YES	NO
ANY PAST INJURY TO THE HEAD OR FACE?		
ANY PAST INJURY TO TEETH?		
ANY PREVIOUS ORTHODONTIC TREATMENT?		
SPEECH THERAPY, TONGUE THRUST THERAPY, OR MYOFUNCTIONAL THERAPY?		
ANY TOOTH SENSITIVITY?		
BLEEDING GUMS?		
ANY UNFAVORABLE REACTION TO PAST MEDICAL OR DENTAL CARE?		
FREQUENT MOUTH ULCERS?		
ANY PREVIOUS EXTRACTIONS?		
RECENT DENTAL X-RAYS?		
HAS ANY NEAR RELATIVE EVER HAD FACIAL OR JAW SURGERY?		
HAS ANY NEAR RELATIVE EVER HAD A NOTICEABLE RECEEDING OR PROTRUDING LOWER JAW?		
HAS ANYONE IN THE FAMILY HAD ORTHODONTIC TREATMENT?		
DO YOU SUCK YOUR FINGER OR THUMB? IF YES, CIRCLE NIGHT OR DAY		
DID YOU EVER SUCK YOUR THUMB OR FINGER?		
DO YOU BITE OR SUCK ON THE INSIDE OF YOUR CHEEK?		
DO YOU BITE YOUR FINGERNAILS OR OTHER OBJECT?		
DO YOU GRIND YOUR TEETH? IF YES, CIRCLE NIGHT AND/OR DAY		
DO YOU CLENCH YOUR JAWS? IF YES, CIRCLE NIGHT OR DAY		
IS YOUR DRINKING WATER AT HOME FLUORIDATED?		
DO YOU GET FLUORIDE TREATMENTS AT SCHOOL OR FROM YOUR DENTIST?		
HAVE YOU EVER HAD PERIODONTAL (GUMS) TREATMENT?		
HAVE YOU EVER HAD A ROOT CANAL?		
DO YOU FREQUENTLY CHEW CHEWING GUM?		
DO YOU SMOKE OR CHEW TOBACCO? IF YES, PLEASE CIRCLE		
ARE YOU A MOUTH BREATHER?		
DO YOU SNORE?		