1981 N. Pebble Creek Parkway
Suite C01
Goodyear, AZ 85395
623-236-9509 Phone
623-234-8670 Fax

ProSmiles
ORTHODONTICS

13210 W. Van Buren Street
Suite 106
Goodyear, AZ 85338
623-251-4629 Phone
623-271-7182 Fax

Office Policies and Procedures

Please Initial Each Line:

___There is a $35.00 charge for missed appointments. Missed appointments can result in prolonged treatment and additional charges. 24 hour notice is sufficient to cancel without a fee.

___ Intervals between appointments vary depending on the treatment and on an individual case-by-case basis. The appointments could be anywhere from 2 to 12 weeks apart.

___ There will be an additional charge for any treatment performed by another doctor in conjunction with orthodontics; i.e., extractions, TMJ treatment, periodontal treatment, oral surgery, dental procedures, etc. These charges are separate from and in addition to your orthodontic treatment.

___ Lack of cooperation by the patient (poor brushing/flossing, not wearing appliances or rubber bands exactly as instructed, missed appointments, excessive appliance breakage, etc.) could result in prolonged treatment, a compromised treatment result, permanent damage to your teeth and additional charges. Consistent poor cooperation will result in the braces being removed before completion of treatment and discontinuation of treatment.

___ The patient/parent is responsible for maintaining good cooperation and a consistent appointment schedule.

___ If a patient has an unscheduled absence from the practice for a period of 100 days, they will be automatically dismissed from the practice.

___ A dental cleaning and exam, along with necessary fillings, must be completed BEFORE appliances are placed. It is also your responsibility to keep regular 3-6 month dental cleaning and check-up appointments with your dentist.

___ All patients are advised to have a periodontal (gum tissue and supporting bone) exam by your general dentist, or in some cases a periodontist, before the initiation of orthodontic treatment. In some instances, you may be required to have an examination by a periodontist before initiating orthodontic treatment.

___ Progress reports and/or verbal communications are given at each appointment.

___ All appointments that are 40 minutes or longer or emergencies will be scheduled before 3:00pm. We will do our best to accommodate you and your schedule.

___ Our office strictly adheres to all state and federal OSHA regulations.

___ We will file with dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating what the orthodontic benefit may be. You are responsible for any unpaid balance from your insurance company.

___ A $25.00 charge will be assessed for all returned checks. Once a check has been returned as NSF, we will only accept cash, money orders or credit cards for payments.

___ Once an account is 60 days past due, the patient will be dismissed from the practice, unless written financial arrangements have been made prior to the 60 day past due status. If a patient is dismissed from the practice, we will see the patient for emergencies only for a period of 30 days.

___ The responsible party will pay any cost associated with collection of your account.

1981 N. Pebble Creek Parkway
Suite C01
Goodyear, AZ 85395
623-236-9509 Phone
623-234-8670 Fax

ProSmiles ORTHODONTICS

13210 W. Van Buren Street
Suite 106
Goodyear, AZ 85338
623-251-4629 Phone
623-271-7182 Fax

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursements for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restrictions. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

1981 N. Pebble Creek Parkway
Suite C01
Goodyear, AZ 85395
623-236-9509 Phone
623-234-8670 Fax

ProSmiles
ORTHODONTICS

13210 W. Van Buren Street
Suite 106
Goodyear, AZ 85338
623-251-4629 Phone
623-271-7182 Fax

Patient Information – Child or Teen

First name: _____ Last name: _____ Middle name: _____

Age: _____ Date of birth: _____ Nickname: _____ Gender: _____

Home address: _____ City: _____ State: ___ Zip: _____

Phone number: _____ Email address: _____

Who is with patient today? _____ Relationship to patient: _____

Patient's general dentist: _____ Who may we thank for referring you to our office? _____

Have we treated another member of the family? __ No __ Yes If yes, name: _____

Has your child visited an orthodontist before? __ No __ Yes If yes, for what reason? _____

What are the main concerns that you would like orthodontics to accomplish? _____

Anything you would like to discuss with the doctor in private? _____

Parents' Information

Father

Marital status: __Single __Married __Widowed __Divorced __Separated __Domestic Partner

Relationship to patient: __Father __Step Father __Guardian

First name: _____ Last name: _____ Middle name: _____

Date of birth: _____ Social Security #: _____

Cell phone: _____ Home phone:_____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer's number: _____

Mother

Marital status: __Single __Married __Widowed __Divorced __Separated __Domestic Partner

Relationship to patient: __Mother __Step Mother __Guardian

First name: _____ Last name: _____ Middle name: _____

Date of birth: _____ Social Security #: _____

Cell phone: _____ Home phone:_____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer's number: _____

1981 N. Pebble Creek Parkway
Suite C01
Goodyear, AZ 85395
623-236-9509 Phone
623-234-8670 Fax

ProSmiles
ORTHODONTICS

13210 W. Van Buren Street
Suite 106
Goodyear, AZ 85338
623-251-4629 Phone
623-271-7182 Fax

Dental Insurance

(Must be filled out completely in order for us to verify benefits)

Name of primary insurance company: _____ Phone: _____

Address of primary insurance company: _____

Subscriber first name: _____ Last name: _____ Middle name: _____

Subscriber date of birth: _____ Social Security #: _____

Subscriber address: _____

ID #: _____ Group #: _____

Name of secondary insurance company: _____ Phone: _____

Address of secondary insurance company: _____

Subscriber first name: _____ Last name: _____ Middle name: _____

Subscriber date of birth: _____ Social Security #: _____

Subscriber address: _____

ID #: _____ Group #: _____

Additional Dental Coverage

Name of insurance company: _____ Phone: _____

Address of insurance company:: _____

Subscriber first name: _____ Last name: _____ Middle name: _____

Subscriber date of birth: _____ Social Security #: _____

Subscriber address: _____

ID #: _____ Group #: _____

1981 N. Pebble Creek Parkway
Suite C01
Goodyear, AZ 85395
623-236-9509 Phone
623-234-8670 Fax

ProSmiles
ORTHODONTICS

13210 W. Van Buren Street
Suite 106
Goodyear, AZ 85338
623-251-4629 Phone
623-271-7182 Fax

Medical History

Is the child currently under care of a physician? __ No __ Yes If yes, for what reason? _____

Name of child's physician: _____ Phone #: _____

Does your child have any history of major illnesses? __ No __ Yes If yes, please describe: _____

List any allergy or drug sensitivity that your child has: _____

Currently taking any medications? __ No __ Yes If yes, please list: _____

Has your child reached puberty? __ No __ Yes

Has your child been treated for any of the following?

__ Arthritis __ Asthma __ Blood Disorder __ Cancer __ Diabetes __ Epilepsy __ Heart Condition __ Nervous Disorder

__ Tuberculosis __ Other:_____

Dental History

Does your child require antibiotics before dental treatment? __ No __ Yes If yes, please explain: _____

Has your child tonsils/adenoids been removed? __ No __ Yes If yes, what age? _____

Have you been informed that your child is missing any permanent teeth? __ No __ Yes

Have you been informed that your child has any extra permanent teeth? __ No __ Yes

Has your child had any injuries to their face, mouth or chin? __ No __ Yes If yes, please explain: _____

Has your child ever complained of pain/tenderness in the jaw joint (TMJ/TMD)? __ No __ Yes

Does/Did your child have any of the following habits?

__ Grinding Teeth __ Finger/Thumb Sucking __ Prolonged Bottle/Pacifier __ Mouth Breathing __ Speech Problems

__ Chewing/Eating Problems __Other: _____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize release of any information related to insurance claims. I consent to examination by the doctor and I authorize payment of any insurance benefits to this office.

Signature: _____ Date: _____

1981 N. Pebble Creek Parkway
Suite C01
Goodyear, AZ 85395
623-236-9509 Phone
623-234-8670 Fax

ProSmiles
ORTHODONTICS

13210 W. Van Buren Street
Suite 106
Goodyear, AZ 85338
623-251-4629 Phone
623-271-7182 Fax

Patient Information – Adult

First name: _____ Last name: _____ Middle name: _____

Age: _____ Date of birth: _____ Nickname: _____ Gender: _____

Home address: _____ City: _____ State: ____ Zip: _____

Phone number: _____ Cell number: _____

Social Security #: _____ Email address: _____

Occupation: _____ Employer: _____ How long? _____

Employer's address: _____ City: _____ State: ____ Zip: _____

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

Have we treated another member of your family? __ No __ Yes If yes, name: _____

Have you visited an orthodontist before? __ No __ Yes If yes, for what reason? _____

What are the main concerns that you would like orthodontics to accomplish? _____

Anything you would like to discuss with the doctor in private? _____

1981 N. Pebble Creek Parkway
Suite C01
Goodyear, AZ 85395
623-236-9509 Phone
623-234-8670 Fax

ProSmiles
ORTHODONTICS

13210 W. Van Buren Street
Suite 106
Goodyear, AZ 85338
623-251-4629 Phone
623-271-7182 Fax

Dental Insurance

(Must be filled out completely in order for us to verify benefits)

Name of primary insurance company: _____ Phone: _____

Address of primary insurance company: _____

Subscriber first name: _____ Last name: _____ Middle name: _____

Subscriber date of birth: _____ Social Security #: _____

Subscriber address: _____

ID #: _____ Group #: _____

Name of secondary insurance company: _____ Phone: _____

Address of secondary insurance company: _____

Subscriber first name: _____ Last name: _____ Middle name: _____

Subscriber date of birth: _____ Social Security #: _____

Subscriber address: _____

ID #: _____ Group #: _____

Additional Dental Coverage

Name of insurance company: _____ Phone: _____

Address of insurance company:: _____

Subscriber first name: _____ Last name: _____ Middle name: _____

Subscriber date of birth: _____ Social Security #: _____

Subscriber address: _____

ID #: _____ Group #: _____

1981 N. Pebble Creek Parkway
Suite C01
Goodyear, AZ 85395
623-236-9509 Phone
623-234-8670 Fax

ProSmiles
ORTHODONTICS

13210 W. Van Buren Street
Suite 106
Goodyear, AZ 85338
623-251-4629 Phone
623-271-7182 Fax

Medical History

Are you currently under the care of a physician? __ No __ Yes If yes, for what reason? _____

Physician's name: _____ Phone #: _____

Do you have any history of major illnesses? __ No __ Yes If yes, please describe: _____

List any allergy or drug sensitivity that you have: _____

Currently taking any medications? __ No __ Yes If yes, please list: _____

Have you been treated for any of the following?

__ Arthritis __ Asthma __ Blood Disorder __ Cancer __ Diabetes __ Epilepsy __ Heart Condition __ Nervous Disorder

__ Tuberculosis __ Other: _____

Dental History

Do you require antibiotics before dental treatment? __ No __ Yes If yes, please explain: _____

Have you been informed that you are missing any permanent teeth? __ No __ Yes

Have you been informed that you have any extra permanent teeth? __ No __ Yes

Have you had any injuries to your face, mouth or chin? __ No __ Yes If yes, please explain: _____

Have you ever had any pain/tenderness in the jaw joint (TMJ/TMD)? __ No __ Yes

Do you have, or have you ever had, any of the following habits?

__ Grinding Teeth __ Finger/Thumb Sucking __Tongue Thrusting __ Chronic Mouth Breathing __ Speech Problems

__ Chewing/Eating Problems __ Other: _____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to examination by the doctor, and I authorize payment of any insurance benefits to this office.

Signature: _____ Date: _____