FOREST
ORTHODONTICS
&
Pediatric Dentistry

To help us better serve you, please complete the following forms to the best of your ability. If you have questions, do not hesitate to let us know. Thank you for choosing our office!

PATIENT

First Name: _____ Last Name: _____
Nickname: _____ DOB (MM/DD/YY): _____ Gender: _____
Address: _____
City, State, Zip: _____

RESPONSIBLE PARTY (PERSON ACCOMPANYING PATIENT)

First Name: _____ Last Name: _____
DOB (MM/DD/YY): _____ Relationship to Patient: _____
Phone Number: _____ Email: _____
Marital Status: _____

INSURANCE POLICY HOLDER

First Name: _____ Last Name: _____
DOB (MM/DD/YY): _____ ID/SSN: _____
Employer: _____
Insurance Company: _____

Address (If different than child): _____
City, State, Zip: _____
Phone Number: _____ Email: _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____
Relationship to Patient: _____
Phone Number: _____ Email: _____

Who can we thank for referring you to us?/How did you hear about us?

_____

_____

PATIENT

First Name: _____ Last Name: _____

DOB (MM/DD/YY): _____

MEDICAL HISTORY

Physician: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Please circle Yes or No (If Yes, please fill in details)

- ☐ Yes or No ☐ Are you taking any medication? _____
- ☐ Yes or No ☐ Any antibiotics needed prior to dental appointment? _____
- ☐ Yes or No ☐ Do you have any allergies? (Please specify) _____
- ☐ Yes or No ☐ Do you have a history of a major illness? _____
- ☐ Yes or No ☐ Have you had any operations? _____
- ☐ Yes or No ☐ Have you ever been involved in a serious accident? _____
- ☐ Yes or No ☐ Do you snore? _____
- ☐ Yes or No ☐ Have you ever smoked, vaped or chewed tobacco? _____
- ☐ Yes or No ☐ Have seen a physician in the last 12 months? Why? _____
- ☐ Yes or No ☐ Are you pregnant? _____
- ☐ Yes or No ☐ Has menstruation started? What age? _____

Circle any of the medical conditions below that you have had or currently have.

- ☐ Abnormal Bleeding/ Hemophilia
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma or Hay Fever
- ☐ Autism
- ☐ Bone Disorders
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gastrointestinal Disorders
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Problems
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/Aids
- ☐ Kidney Problems
- ☐ Nervous Disorders
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Radiation/Chemotherapy
- ☐ Reflux
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Tumor or Cancer
- ☐ Ulcer

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

DENTAL HISTORY

Who is your current/previous dentist?: _____ Date of Last Visit: _____

What concerns you most about your teeth?: _____

- ☐ Yes or No ☐ Is any part of your mouth sensitive to temperature? _____
- ☐ Yes or No ☐ Is any part of your mouth sensitive to pressure? Where? _____
- ☐ Yes or No ☐ Do your gums bleed when you brush? _____
- ☐ Yes or No ☐ Do you have any type of thumb or tongue habit? _____
- ☐ Yes or No ☐ Are you a mouth breather? _____
- ☐ Yes or No ☐ Have you ever seen an orthodontist? If so, who and when? _____
- ☐ Yes or No ☐ What is your attitude toward receiving orthodontic treatment? _____
- ☐ Yes or No ☐ Has anyone in your family received orthodontic treatment? _____
  How did they feel about the result? _____
- ☐ Yes or No ☐ Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- ☐ Yes or No ☐ Are you aware of your jaw clicking or popping? _____
- ☐ Yes or No ☐ Are you aware of clenching your teeth during the day? _____
- ☐ Yes or No ☐ Have you ever been told that you grind your teeth? _____
- ☐ Yes or No ☐ Do you have “tension” headaches? _____
- ☐ Yes or No ☐ Have you ever experienced chronic ringing in your ears? _____

_____ _____

Responsible Party Signature Date

APPOINTMENT POLICY

The scheduled appointment is reserved specifically for your child. Any changes in this appointment affects many patients. If a cancellation is unavoidable, please call the office at least 48 hours so that we may give that time to another patient.

- Certain appointment types may require appointments during work/school hours. Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- Please arrive 5 minutes or more before your scheduled appointment. This will allow time to complete any additional paperwork and see your child on time.
- If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule time for next available appointment time.
- Please call at least 48 hours in advance if you need to cancel or reschedule your appointment.
- Broken or missed appointments affect many people. If two broken or missed appointments occur or two cancellations without 48 hour notice, we reserve the right to charge $47 fee per missed appointment.
- We understand unavoidable emergencies or circumstances come up.

FINANCIAL POLICY

Thank you for choosing our office for your dental care. The following are our financial policies:

- **Payment Responsibility:** Please be aware that the parent/guardian(s) bringing the child to Forest Orthodontics & Pediatric Dentistry LLC are legally responsible for payment of all charges. The office cannot send statement to other parties.
- **Payment policy:** I/We understand that payment of services is expected when treatment is rendered and charges are ultimately our responsibility. As a courtesy, Forest Orthodontics & Pediatric Dentistry will submit to insurance on our behalf. I/We understand that our insurance may not always cover the total amount for services rendered and I/w will be responsible for any remaining balance. Under certain circumstances payment, or a down payment, may be required in advance of treatment. For the convenience of our patients, we accept cash, personal checks (which cannot be postdated), Visa, Mastercard, American Express, Discover, Apple Pay, and Samsung Pay. Additionally, we offer CareCredit for financing options.
- **Dental Insurance:** The type of plan chosen by you, and/or by your employer, determines your insurance benefits. We make the beset attempt to estimate your insurance benefits as accurately as possible. However, changes in benefits and exclusions, which may be unique to your policy may result in a refund or additional balance after insurance has paid. We may keep your payment information stored in our secure payment processor, Vanco, in case there is a remaining patient portion due, Although insurance is a wonderful thing to have, it is not always easy to understand. Please be aware that is it your responsibility to understand how it pays for services. We will be delighted to help you as best we can. You can also call the insurance company directly with inquiries about the plan.
- **Emergency Treatment:** All emergency treatments must be paid in full at the time service is rendered.

- **Outstanding Balances:** I/We recognize that under certain circumstances an account balance may be incurred. Forest Orthodontics & Pediatric Dentistry require that all outstanding balances be paid in full within 30 days unless other arrangements have been made. If the balance becomes delinquent after those 30 days, interest will be added at the rate of 1.5% per month (18% per annum) until the account is paid in full. All returned checks will incur a $35 return check fee which will be added to the account. In addition it is understood that if Forest Orthodontics & Pediatric Dentistry is forced to use an outside collection agency and/or attorney for collections that a $50 administrative fee and up to 30% of the principal balance will be added to the account as collection fees. Lastly, if Forest Orthodontics & Pediatric Dentistry is forced to proceed with litigation to collect the unpaid balance, it is understood and agreed to that we will be liable for all court costs whether judgment has been entered or not.

PEDIATRIC DENTAL PATIENTS
INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES

Please read carefully and ask about anything on this form. We will be happy to explain it further.

Every effort will be made to obtain your child's cooperation through warmth, charm, humor, and understanding. When these fail there are several behavior management techniques used to eliminate or minimize disruptive behavior. These are routinely used and accepted by the American Academy of Pediatric Dentistry, and are described below.

- **Tell-show-do:** The dentist or assistant explains to the child what is to be done by demonstrating on a model or on the child's finger. Then the procedure is done on the patient's tooth. Praise is used to reinforce cooperative behavior.

- **Positive Reinforcement**: This technique rewards the child who displays any desirable behavior. Rewards include compliments, praise, and a pat on the arm or a prize.

- **Voice Control:** The attention of a child with disruptive behavior is gained by changing the tone or increasing the volume of the practitioner's voice.

- **Bite Block/Mouth Props:** A rubber device is gently placed in the child's mouth to prevent either intentional or unintentional closure on the dentist's fingers or drill during dental treatments/fillings.

ORTHODONTIC BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides a 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 tooth 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 education and promotional purposes. I have truthfully answered all the information in the Medical History and Dental History forms and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Derek J. Bock to perform a complete orthodontic evaluation.

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance, personnel decisions; participation in managed care plans; defense of legal matters; business planning, and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you or special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research; uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes, or for the evaluation and health of members of the foreign service; disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

- disclosures to “business associates” who perform health care operations for us and who commit to respect the privacy of your health information;
- photographic release for teaching or board certification purposes

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will leave you a reminder message on your answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written “authorization form.” The content of an “authorization form” is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it’s your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- The law gives you many rights regarding your health information. You can: ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or email shown at the beginning of the notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or out rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or email shown at the beginning of this notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations, disclosures with your authorization, incidental disclosures, disclosures required by law, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax, or email shown at the beginning of this notice.
- Additional paper copies of this Notice of Privacy Practices available upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information we already have as well as to such information that we may generate in the future, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF REVIEWING POLICIES

Please initial each line below to acknowledge that you have read and understood the policies provided.

_____ Appointment Policy

_____ Financial Policy

_____ Pediatric Dental Informed Consent and/or Orthodontic Benefits

_____ Notice of Privacy Practice

☐ Yes, I would like copies of the Appointment Policy, Financial Policy, Pediatric Dental Informed Consent and/or Orthodontic Benefits, and Notice of Privacy Practice to take home for my records.

☐ No, I waive my right to take copies home, but I know that I can ask for them at any time.

_____ _____

Patient(s) Name(s) Responsible Party Signature

_____

Date

HIPAA Consent

Signature Date HIPAA Consent Our Notice of Privacy Practices provides informal on about how we may use and disclose protected health information about you. The Notice contains a Patient Rights sec)on describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the pa)ent has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The completion of the non-guardian consent form is required if HIPAA protected information needs to be shared with a non-guardian (e.g. grandparent, care-taker, sibling, non-guardian parent).

The consent was signed by:

_____ _____

Signature Date