AR DENTISTRY & BRACES

A RockDental BRANDS COMPANY

Patient Information

Date: _____

Patient Name: _____ I prefer to be called: _____
Birthdate: _____ Patient SSN : _____ Driver's License #: _____
Address: _____ City: _____ St: ____ Zip: _____
Email Address: _____ Phone: Work _____ Cell _____
The best way to contact me is on my: ▢ Work Phone ▢ Cell Phone ▢ Text Message ▢ Email
Gender: ▢ Male ▢ Female
Marital Status: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced
If you are a student, please list your school: _____
How did you hear about our office? _____

Employer

Patient's Employer: _____
Employer Address: _____ City: _____ St: ____ Zip: _____

Spouse

Spouse's Name: _____ Employer: _____
Birth date: _____ SSN: _____ Driver's License #: _____
Email Address: _____ Phone: Work _____ Cell _____

Emergency Contact

Name of Emergency Contact: _____ Relationship to patient: _____
Email Address: _____ Phone: Work _____ Cell _____

Parent or Guardian Information: *If the patient is a child.*

Mother: _____ Relationship: ▢ Mother ▢ Stepmother ▢ Guardian
Address: _____ City: _____ St: ____ Zip: _____
Email Address: _____ Phone: Work _____ Cell _____
The best way to contact me is on my: ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email
Birthdate: _____ SSN : _____ Driver's License #: _____
Check the appropriate box: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced

Father: _____ Relationship: ▢ Father ▢ Stepfather ▢ Guardian
Address: _____ City: _____ St: ____ Zip: _____
Email Address: _____ Phone: Work _____ Cell _____
The best way to contact me is on my: ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email
Birthdate: _____ SSN : _____ Driver's License #: _____
Check the appropriate box: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced

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Person Responsible for Account

Name: _____ Relationship to patient: _____
Billing Address: _____ City: _____ St: ____ Zip: _____
Email Address: _____ Phone: Work _____ Cell _____
The best way to contact me is on my: ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email
Birthdate: _____ SSN : _____ Driver's License #: _____

Insurance Information

Do you have orthodontic coverage? ▢ Yes ▢ No
Name of Insured: _____ Birth date: _____
Relationship to patient: _____ Insured SSN: _____
Name of employer: _____ Work Phone: _____
Work Address: _____ City: _____ St: ____ Zip: _____
Insurance Company: _____ Group No: _____ ID No: _____
Ins. Co. Address: _____ City: _____ St: ____ Zip: _____
Ins. Co. Phone: _____
Do you have any additional insurance? ▢ Yes ▢ No If yes, complete the following.

Name of Insured: _____ Birth date: _____
Relationship to patient: _____ Insured SSN: _____
Name of employer: _____ Work Phone: _____
Work Address: _____ City: _____ St: ____ Zip: _____
Insurance Company: _____ Group No: _____ ID No: _____
Ins. Co. Address: _____ City: _____ St: ____ Zip: _____
Ins. Co. Phone: _____

Dental Health History

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

_____

Have you ever had or been evaluated for orthodontics treatment? ▢ Yes ▢ No
Have you ever had a serious or difficult problem associated with any previous dental work? ▢ Yes ▢ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ▢ Yes ▢ No
Your current dental health is: ▢ Good ▢ Fair ▢ Poor
Do you like your smile? ▢ Yes ▢ No
Do your gums ever bleed? ▢ Yes ▢ No
Have you ever had an injury to your? ▢ Mouth ▢ Teeth ▢ Chin
Do you generally breathe through your mouth? ▢ Yes ▢ No
If yes, please select when: ▢ While Awake ▢ While Asleep
Do you have any missing or extra permanent teeth? ▢ Yes ▢ No
Have you ever taken Phen-Fen? (aka: Redux and Pondimin) ▢ Yes ▢ No If yes, when? Date: _____

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Do you smoke or use tobacco in any form? ▢ Yes ▢ No

Medical Health History

Do you have a personal physician? ▢ Yes ▢ No Date of last visit?_____
Physician's Name: _____ Practice Phone: _____
Address: _____ City: _____ St: ____ Zip: _____
Are you currently under the care of a physician? ▢ Yes ▢ No If yes, please explain:_____
Your current physical health is: ▢ Good ▢ Fair ▢ Poor
Please list any medications you are currently taking:

_____

_____

For Women:

Are you taking birth control? ▢ Yes ▢ No
Are you pregnant? ▢ Yes ▢ No ▢ Uncertain Week #: _____
Are you nursing? ▢ Yes ▢ No

Have you ever had any of the following disease or medical problems? Please check appropriate box.

- ▢ Abnormal Bleeding
- ▢ Anemia
- ▢ Arthritis
- ▢ Artificial Bones/Joints/Valves
- ▢ Asthma
- ▢ Blood Transfusion
- ▢ Cancer or Chemotherapy
- ▢ Congenital Heart Defect
- ▢ Diabetes
- ▢ Drug or Alcohol Abuse
- ▢ Emphysema
- ▢ Epilepsy, Seizures or Fainting
- ▢ Fever Blister / Herpes
- ▢ Glaucoma
- ▢ Heart Attack / Stroke
- ▢ Heart Murmur
- ▢ Heart Surgery / Pacemaker
- ▢ Hemophilia
- ▢ Hepatitis
- ▢ High or Low Blood Pressure
- ▢ HIV+ / AIDS
- ▢ Kidney Problems or Diseases
- ▢ Mitral Valve Prolapse
- ▢ Psychiatric Problem
- ▢ Radiation Therapy
- ▢ Respiratory Problems
- ▢ Rheumatic / Scarlet Fever
- ▢ Shingles
- ▢ Sickle Cell Disease / Traits
- ▢ Sinus Problems
- ▢ Thyroid Problem
- ▢ Tuberculosis (TB)
- ▢ Ulcers / Colitis
- ▢ Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following? Please check appropriate box.

- ▢ Aspirin
- ▢ Tetracycline
- ▢ Sulfur Drugs
- ▢ Erythromycin
- ▢ Latex
- ▢ Iodine
- ▢ Penicillin
- ▢ Any Metals or Plastics
- ▢ Plastic
- ▢ Codeine
- ▢ Dental Anesthetics
- ▢ Other

Please list any other drugs or materials that you are allergic to:

_____

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Text and Email Policy

Arkansas Dentistry & Braces can email and/or text you appointment reminders and general information about our services. If you would like to receive communications via email or text in the future, please read and sign the consent attached below.

Consent to Email and/or Text Message for Appointment Reminders and Other Communications:

You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but chargers from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

Communication Preference: ▢ Text ▢ Email

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved. Any account that payment has not been received within 90 days will be considered for collection by an outside agency. For your convenience, our office offers the following method of payment: cash, check, Mastercard, Discover, American Express, and Care Credit. (Care Credit applications are available upon request.)

This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurances does not cover. I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Patient Name

_____ _____

Patient or Guardian Signature **Date**

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Non-Discrimination Policy

DISCRIMINATION IS AGAINST THE LAW

Rock Dental Brands complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Rock Dental Brands does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Rock Dental Brands:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Paul D. McNiel, Director of Dental Operations.

If you believe that Rock Dental Brands has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Paul D. McNiel, Chief Compliance Officer
610 Clinton Ave. Little Rock, AR. 72201
501-259-8331
paul.mcniel@rockdentalbrands.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Paul D. McNiel, Director of Dental Operations is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

By signing below, I agree that I have read and understand Rock Dental Brands' Non-Discrimination Policy.

_____ _____

Signature **Date**

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Translation services are available in the following languages:

አማርኛ
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-844-313-7625.

العربية
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-313-7625 رقم

中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-844-313-7625

Oroomiffa
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-313-7625.

فارسی
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-844-313-7625 تماس بگیرید.

Français
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-313-7625.

Deutsche
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-313-7625.

ગુજરાતી
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-313-7625.

हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-313-7625.

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-313-7625.

日本語
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-313-7625。

한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-313-7625.

ລາວ
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-844-313-7625

Marshallese
LALE: Ñe kwōj kōnono Kajin M̧ajōļ, kwomaroñ bōk jerbal in jipañ ilo kajin n̤e am̤ ejjeļọk wōn̤āān. Kaalọk 1-844-313-7625.

Pennsylvania Dutch
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-313-7625.

português
ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-844-313-7625.

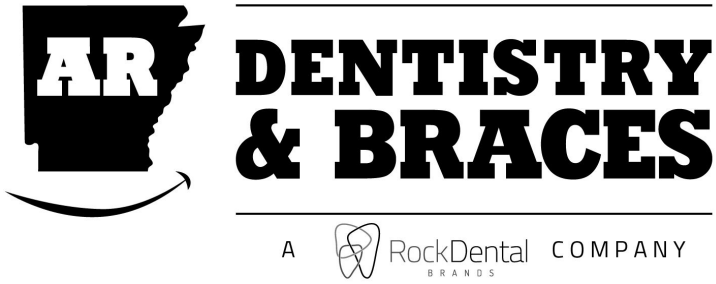
русский
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-313-7625.

Srpsko-hrvatski
OBAVJEŠTENJE: Ako govorite srpskohrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-313-7625.

Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-313-7625.

pilipino
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-313-7625.

Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-313-7625.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