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

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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:

_____

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 beheld 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.

_____

Signature **Date**

This office reserves the right to verify the credit status of potential patients and or the parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

Signature **Date**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

_____

Signature **Date**

Text and Email Policy

Westrock Orthodontics 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.

Patient Name _____ Guardian Name (if patient is a minor) _____

Communication Preference: ▢ Text ▢ Email

_____

Signature **Date**

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Notice of Privacy Practices and Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient Name **Relationship to Patient**

_____ _____

Signature **Date**

Please, list below any person who can receive PHI (Protected Health Information) on this patient.

Name	Relationship	Treatment Info.		Ledger	
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No

OFFICE USE ONLY *I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:*

Date	Initials	Reason

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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, Chief Compliance Officer.

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, Chief Compliance Officer 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 ተዘጋጀተዋል፡ 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
સૂચના: 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, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-313-7625

Marshallese
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. 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.