
**New patients**

Welcome to our practice. Our primary purpose is to serve you and your family, to provide for your orthodontic needs in a considerate and caring fashion. For your protection this office has the most modern equipment, the latest techniques, above all, we follow OSHA guidelines in advanced sterilization technology for both staff and patient protection.

**Consent for Services**

As a Condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency orthodontic services, and any services performed without previous financial arrangements, must be paid for in full at time services are performed.

**(Initials)_____**

**Medical and Dental Authorization**

I have read the information on the health questionnaire and it is accurate to the best of my knowledge. I understand that the orthodontist in order to help determine appropriate and helpful orthodontic treatment will use this information provided. If there are any changes in my medical status, I will inform the dentist.

**(Initials)_____**

**Insurance Authorization**

If you have dental insurance, we will gladly process your forms. However, we request that you pay your **ESTIMATED** portion when services are rendered. Please remember that our contract for payment is with you and not your insurance carrier.

We are happy to bill your insurance as a courtesy to you, when you have provided us with your complete insurance information. We allow 45 days from the date of service for payment from an insurance company. After this period, we ask you to become responsible for payment of all unpaid fees.

**(Initials)_____**

**Payment Options**

**The down payment is due at the time that we start treatment**. We accept cash, checks, and all major credit cards. We also have two no interest payment plans, Care Credit and an in-house financing payment plan option, that allows you to start treatment today and spread payments over the time of your treatment. Applying for Care Credit and All Care only takes a few minutes and there is no fee to apply.

**(Initials)_____**

## Caregiver other than Parent/Guardian

***(For patients under 18 years old only)***

I am giving the following adults permission to bring my child to their orthodontic appointments. I understand that only myself and those listed below will have the authority to authorize treatment. I understand that any person bringing the patient in for treatment not listed below must have a letter of consent from me or treatment could be refused or delayed. This authorization will remain in effect unless designated in writing that such consent for treatment of minor is cancelled. I will notify Wild West Orthodontics of any changes.

| NAME (AUTHORIZED CAREGIVER(S) | PHONE | RELATIONSHIP TO PATIENT |
|---|---|---|
| NAME (AUTHORIZED CAREGIVER(S) | PHONE | RELATIONSHIP TO PATIENT |

**I HAVE READ THE ABOVE OFFICE POLICIES AND CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.**

_____Date_____

Signature of patient, parent or guardian

## PATIENT INFORMATION

Name_____ Birth date_____ SS#_____

Address_____ City_____ State _____ Zip_____

Sex _____M _____F ____Married_____Widowed____Minor____Single____Divorced

E-mail _____ Do we have your permission to email you our news letter ***YES / NO***

Home Phone _____Cell Phone _____

Pharmacy Name & Address_____ Phone _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____Phone _____

I give_____ permission for ***Wild West Orthodontics*** to communicate with them regarding my Dental treatment or any question regarding billing, and/or my appointments

## Responsible Party

Name of Person
Responsible for this Account _____Relation to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthday_____

Employer _____ Work Phone _____

## Insurance Information

Name of Insured _____ Relation to Patient _____

Birthday _____ Social Security # _____Date Employed _____

Employer _____ Work Phone _____

Employer Address _____City _____State _____Zip _____

Insurance Company _____Group #_____

Address _____City _____ State _____ Zip _____

Insurance ID# _____ Insurance Phone _____

## Additional Insurance Information

Name of Insured _____ Relation to Patient _____

Birthday _____ Social Security # _____Date Employed _____

Employer _____ Work Phone _____

Employer Address _____City _____State _____Zip _____

Insurance Company _____Group #_____

Address _____City _____ State _____ Zip _____

Insurance ID# _____ Insurance Phone _____

*** Important Medical Alert ***

A connection between **Fosamax**, and other bisphosphonates, with a serious bone disease called Osteonecrosis of the jaw (ONJ) has been found.

**Bisphosphonates** are commonly used in tablet form to **prevent and treat osteoporosis** in postmenopausal women. They are also used in the treatment of **Paget's disease.** Stronger forms given orally or intravenously (IV) are commonly used in the **management of advanced cancers** including, but not limited to, lung cancer, breast cancer, prostate cancer, multiple myeloma, and other masatic cancers.

**Have you ever taken any of the following bisphosphonates? Circle Yes or No**

**Y N** Alendronate (Fosamax)
**Y N** Clodronate (Bonefos, Ostac)
**Y N** Etidronate (Didronel)
**Y N** Ibandronate (Boniva)
**Y N** Pamidonate (Aredia)
**Y N** Raloxifene (Evista)
**Y N** Risedronate (Actonel)
**Y N** Terparatide (Foreto)
**Y N** Tiludronate (Skelid)
**Y N** Zoledronate (Zometa)

If yes, when? _____

_____

Prescribing Doctor: _____ _____

Name Phone

_____

Patient or Responsible Party Name

_____ _____

Patient or Responsible Party Signature Date

## Dental History

Reason for today's visit _____ Date of last dental care & X-rays _____

**Circle if you have had problems with any of the following:**

Bad Breath Bleeding Gums Grinding Teeth Sensitivity to hot Loose teeth or broken fillings Sensitivity to sweets
Clicking or popping jaw Periodontal treatment Sensitivity when biting Sensitivity to cold Food Collection between the teeth
Sensitivity to cold Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

## Medical History

Physician's Name _____ Date of last visit _____

Physician's Number _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). _____ Yes _____No

Have you had any serious illnesses or operations? **Yes/No** If yes, describe _____

Have you ever had a blood transfusion? **Yes/No** If yes, give approximate dates _____

Are you taking any blood thinner? **Yes/No** If yes, describe _____

(Women) Are you pregnant? _____ Yes _____No Nursing? ____ Yes ____No Taking birth control pills?_____ Yes _____No

**Have you had any of the following: circle *Yes or No***

| | | | |
|---|---|---|---|
| Anemia **Yes/No** | Congenital Heart Lesions **Yes/No** | Hepatitis **Yes/No** | Scarlet Fever **Yes/No** |
| Arthritis, Rheumatism **Yes/No** | Cortisone Treatments **Yes/No** | Hernia Repair **Yes/No** | Shortness of Breath **Yes/No** |
| Artificial Joints **Yes/No** | Cough, Persistent **Yes/No** | High Blood Pressure **Yes/No** | Skin Rash **Yes/No** |
| Artificial Heart Valves **Yes/No** | Cough up Blood **Yes/No** | HIV/AIDS **Yes/No** | Stroke **Yes/No** |
| Asthma **Yes/No** | Diabetes **Yes/No** | Jaw Pain **Yes/No** | Thyroid Problems **Yes/No** |
| Back Problems **Yes/No** | Epilepsy **Yes/No** | Kidney Disease **Yes/No** | Ulcer **Yes/No** |
| Bleeding Abnormally **Yes/No** | Fainting **Yes/No** | Liver Disease **Yes/No** | Tobacco Habit **Yes/No** |
| Blood Disease **Yes/No** | Glaucoma **Yes/No** | Mitral Valve Prolapse **Yes/No** | Tonsillitis **Yes/No** |
| Cancer **Yes/No** | Headaches **Yes/No** | Pacemaker **Yes/No** | Tuberculosis **Yes/No** |
| Chemical Dependency **Yes/No** | Heart Murmur **Yes/No** | Radiation Treatment **Yes/No** | Venereal Disease **Yes/No** |
| Chemotherapy **Yes/No** | Heart Problems **Yes/No** | Respiratory Disease **Yes/No** | |
| Circulatory Problems **Yes/No** | Hemophilia **Yes/No** | Rheumatic Fever **Yes/No** | Swelling of Feet or Ankles **Yes/No** |

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

## Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ assign directly to **Wild West Orthodontics** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Print Patient Name


**Would you want to be part of our Social Media?**

☐ Yes!

☐ I Decline

I, _____, give Wild West Orthodontics permission to show my before and after pictures on their Facebook, Instagram, Tik-Tok, and/or displayed on their patient wall.

_____ _____

Patient Name Printed Date

_____ _____

Patient/Parent Signature Date

# 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.**

**Our commitment here at Wild West Orthodontics is to serve our patients with professionalism and caring, being sure at all times to PROTECT the privacy and security of all Protected Health Information.**

**During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:**

- **During treatment, we may find it necessary to consult with a dental laboratory.**
- **For payment purposes, we may use the services of a billing service.**
- **During orthodontic care, we may need to consult with your physician or previous dentist.**
- **For payment purposes, we need to supply information requested from your dental insurances company.**

**We here at Wild West Orthodontics we are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.**

**If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer: (623)536- 2040.**

**I have read and understand the above Notice of Privacy Practices.**

**_____ Date: _____/_____/_____**

**(Patient or Legal Guardian)**

# WILD WEST ORTHODONTICS
# (623) 535-6603

## CANCELLATION POLICY

YOUR DENTAL APPOINTMENT HAS BEEN RESERVED ESPECIALLY FOR YOU.

THE OFFICE MANAGER WILL CALL THE DAY BEFORE YOUR SCHEDULED APPOINTMENT TO CONFIRM THE TIME SET FOR YOU.

IF YOU NEED TO CANCEL YOUR APPOINTMENT FOR ANY REASON, KINDLY GIVE US **24 HOURS NOTICE**, OR A **$40.00 CANCELLATION FEE** WILL BE CHARGED TO YOUR ACCOUNT.

THERE IS A **5 MINUTES** GRACE PERIOD FOR APPOINTMENTS. AFTER 5 MINUTES YOUR APPOINTMENT WILL BE CONSIDERED MISSED.

THANK YOU FOR HELPING US PROVIDE QUALITY DENTAL CARE, BY RESPECTING THE APPOINTMENT TIME SET FOR YOU.

_____ _____/_____/_____

Signature Date