Patient Registration

BAY AREA ORTHODONTICS

Patient Information

First Name:	Last Name:		Preferred or Nick Name:
Address (Patient's Primary Residence - No PO Boxes Please):			☐ Resides Full-Time ☐ Resides Part-Time | What Percent? %
City:	State:		Zip:
SSN#:	Age:	Birth Date:	☐ Male ☐ Female
Email:	Phone#: ☐ Cell ☐ Home ☐ Work		Alt Phone#: ☐ Cell ☐ Home ☐ Work

Referral Information

Has the patient ever been seen in any of our office(s) before? ☐ No ☐ Yes | ☐ Morgan Hill ☐ Santa Clara ☐ Sunnyvale

Does the patient have a sibling that has been seen in any of our office(s) before? ☐ No ☐ Yes | ☐ Morgan Hill ☐ Santa Clara ☐ Sunnyvale

Where did you hear about us (Please Specify Name)?

☐ Family/Friend Referral: _____ ☐ Doctor Referral: _____ ☐ Internet Search, Browser: _____

☐ Event:_____ ☐ Insurance Provider: _____ ☐ Other: _____

Parent | Person(s) Responsible

The **primary person** listed below is the person that is financially responsible for any and all services provided by Bay Area Orthodontics. If there is a change, the person below should inform Bay Area Orthodontics prior to service(s) rendered.

Primary Responsible Person

☐ Same As Patient

First Name	Last Name:	
DOB:	SS#:	
Phone#:		☐ Cell ☐ Home ☐ Work
Alt Phone#:		☐ Cell ☐ Home ☐ Work
Home Address:		
City:	State:	Zip:
Relation to Patient: ☐ Biological Parent ☐ Step-Parent ☐ Other_____		
Email:		

Secondary Responsible Person

First Name	Last Name:	
DOB:	SS#:	
Phone#:		☐ Cell ☐ Home ☐ Work
Alt Phone#:		☐ Cell ☐ Home ☐ Work
Home Address:		
City:	State:	Zip:
Relation to Patient: ☐ Biological Parent ☐ Step-Parent ☐ Other_____		
Email:		

Primary Insurance

Insured's First Name:		Last Name:
DOB:	SEX: M F	Insured's Relation to Patient: ☐ Biological Parent ☐ Step-Parent ☐ Other_____ ☐ Self
Home Address: ☐ Same as Primary Resp. Person ☐ Same as Second Resp. Person		
City:	State:	Zip:
Insured's SSN#:		
Employer:	Employer's Phone #:	
Insurance Company:	Insurance Company Phone #:	
Group #:	Policy Number:	
Policy Effective Date:	Union Name and Local Union #:	

Secondary Insurance ☐ There isn't a secondary insurance

Insured's First Name:		Last Name:
DOB:	SEX: M F	Insured's Relation to Patient: ☐ Biological Parent ☐ Step-Parent ☐ Other_____ ☐ Self
Home Address: ☐ Same as Primary Resp. Person ☐ Same as Second Resp. Person		
City:	State:	Zip:
Insured's SSN#:		
Employer	Employer's Phone #:	
Insurance Company:	Insurance Company Phone #:	
Group #:	Policy Number:	
Policy Effective Date:	Union Name and Local Union #:	

Emergency Contact 1

First Name	Last Name:
Relationship to Patient:	
Phone#:	☐ Cell ☐ Home ☐ Work
Alt Phone#:	☐ Cell ☐ Home ☐ Work

Emergency Contact 2

First Name	Last Name:
Relationship to Patient:	
Phone#:	☐ Cell ☐ Home ☐ Work
Alt Phone#:	☐ Cell ☐ Home ☐ Work

Initials Consents & Verifications

	PHOTO CONSENT | I authorize Bay Area Orthodontics to post images and/or videos of the patient on their website and social media for promotional and marketing purposes. I also understand that I reserve the right to revoke this authorization in writing at any time. ☐ I do not consent for my child's photo to be used as stated above. (Initials not required if you do not consent)
	PRIOR EXPRESS CONSENT FOR CALLS, TEXTS, & EMAILS | By providing phone numbers and email addresses now or in the future, I consent and agree that Bay Area Orthodontics may call me, leave me a voicemail, or send me a text, email or other electronic message for the purposes relating to the servicing or collection of any account that I may establish with BAO or any other informational purposes related to my account or treatment ("Communication"). I also agree that BAO may include my personal information in a communication. BAO will not charge for a communication, but my service provider may. I agree that BAO may monitor and record any telephone calls to assure the quality of its service or for other reasons. ☐ I exclude consent to emails ☐ I exclude consent to text
	INFORMATION VERIFICATION | I, _____ acknowledge that the information provided herein is true and complete to the best of my knowledge. I authorize Bay Area Orthodontics or anyone acting on my behalf to obtain, review and/or share with its designated agents, or any assignee of my account, my information for the purpose of verifying my identity, or updating, renewing, servicing, modifying, or collecting my account. This authorization is valid as long as any amounts are owed on my account to Bay Area Orthodontics or any assignee of my account. I acknowledge that BAO may report information about my account to consumer reporting agencies and other persons who may legally receive such information. Late payments, missed payments or other default on my account may be reflected in my credit report.

Printed Name of Primary Responsible Party

Signature of Primary Responsible Party Date

Office Information

Today's Date: _____

Broken Appointments

_____ Initials

Scheduled appointment times have been reserved specifically for our patients. We request 48 hours notice if you need to cancel an appointment. We are aware that unforeseen events sometimes require missing an appointment. **However, if you do miss an appointment without notifying us 48 hours in advance, a cancellation fee of $50 may be applied to your account.**

Routine Check-Up

_____ Initials

We recommend that the patient has routine cleanings and exams that follows the guidelines set forth by the American Dental Association and the American Academy of Pediatric Dentists. These guidelines recommend children and adults receive a cleaning, exam and fluoride treatment twice a year.

Infection Control

_____ Initials

We utilize the most effective infection control measures and fully comply with all OSHA and CDC standards for sterilization. We maximize our use of disposable materials and sterilize all of our hand instruments.

Insurance & Payment Commitment

_____ Initials

Our office will make every effort to gather all relevant information regarding your insurance coverage before the visit. We will pre-register your child based on the information given to us at the time you made the appointment. If you have insurance to help pay for your services, our office will bill your insurance as a courtesy. Understand that dental insurance may cover only part of your orthodontic treatment, based on your specific dental insurance benefit plan. We will do our best to provide you with an estimate based on your plan. Please understand that the contract for dental insurance is between you and your insurance company. Any disputes of insurance coverage need to be addressed with your insurance company directly by you.

_____ Initials

If the patient does not have insurance, full payment is due at the time treatment is rendered. Please be advised if payment is not made as agreed, your account may be sent to an outside collections agency.

_____ Initials

By signing, you _____accept as your personal responsibility all charges to your account regardless of insurance coverage. In addition, you authorize and request your insurance company to pay directly to Bay Area Orthodontics any insurance benefits otherwise payable to you. Any estimated co-payment is expected at the time services are rendered.

Acknowledgment of Receipt

_____ Initials **Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Office Manager of the location. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

_____ Initials **Dental Materials Fact Sheet:** This is information provided by the dental board of California to advise patients of the types of materials used in the dental office. By signing this form you acknowledge receipt of the fact sheet. Dental Materials Fact Sheet dated May 2004.

_____ Initials **Consent & Receipt of Notice of Privacy Practices:** I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. Bay Area Orthodontics's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and I may contact Bay Area Orthodontics at any time to obtain a current copy of their Notice of Privacy Practice.

Signature of Individual or Legal Representative Witness: _____

Printed Name of Individual or Legal Representative: _____

Witness: _____ Date: _____

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because: (Check One)

☐ Individual refused to sign
☐ Communication barrier prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify) _____

BAO Staff _____ Date: _____

I, _____ have read and understand the Office Information provided above and agree to abide by its contents:

_____

Signature of Primary Responsible Party Date

Health History

BAY AREA ORTHODONTICS

Patient Name: _____ Birth Date: _____
Nickname: _____ ☐ Male ☐ Female
Person completing this form: _____ Relationship to patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other

Dental History

Does the patient see a dentist for routine exams and cleanings? ☐ Yes ☐ No
Has the patient ever had a reaction from local anesthetic? ☐ Yes ☐ No
Does the patient have any of the following habits? ☐ Thumb/Finger Sucking ☐ Clenching/Grinding Teeth ☐ Snoring/Sleep Apnea

Medical History

Is patient in good health? ☐ No ☐ Yes
Are the patient's immunizations up to date? ☐ No ☐ Yes
Is the patient taking any medication? ☐ No ☐ Yes, please list all: _____
Has the patient ever been premedicated with antibiotics for your dental treatment? ☐ No ☐ Yes
Has the patient had any trouble associated with dental treatment? ☐ No ☐ Yes
Has the patient ever had a serious illness or surgery or been in the hospital overnight? ☐ No ☐ Yes, date: _____
Has the patient ever had a blood transfusion? ☐ No ☐ Yes, date: _____
Does the patient have any tubes, shunts, prosthesis? ☐ No ☐ Yes, please explain: _____
Has the patient had complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions? ☐ No ☐ Yes _____

Has the patient ever been diagnosed with any of the following conditions?

Yes	No							
☐	☐	Allergies to:	☐ Latex	☐ Penicillin	☐ Tetracycline	☐ Aspirin	☐ Sulfa Drugs	☐ Phen-Phen
			☐ Nuts	☐ Milk/Dairy	☐ Dyes, Metals or Acrylics	☐ Other: _____		
☐	☐	Asthma, medication: _____						
☐	☐	Diabetes, medication: _____						
☐	☐	Heart disease	☐ Heart murmur	☐ Heart congenital defect	☐ History of rhematic fever			
☐	☐	Blood disorders	☐ Anemia	☐ Sickle cell anemia	☐ Hemophilia	☐ Other		
☐	☐	Excessive bleeding after dental treatment						
☐	☐	Cancer or chemotherapy						
☐	☐	Radiation treatment of any kind						
☐	☐	Hepatitis or liver disease						
☐	☐	Hearing loss						
☐	☐	Kidney disease						
☐	☐	Respiratory disease						
☐	☐	Epilepsy or seizures						
☐	☐	Behavior problems/learning disability						
☐	☐	Cerebral Palsy						
☐	☐	Autism						
☐	☐	Developmental or constitutional delay, functional age level: _____						
☐	☐	Skin rash						

Is there any other medical condition or syndrome from which the patient suffers? ☐ No ☐ Yes, please explain: _____

Comments: _____

I have filled out this questionnaire completely. I have advised you of all medical problems of which I am aware and I authorize and give full consent to perform dental services agreed upon between doctor and patient representative to be necessary or advisable, including examination, radiographs, prophylaxis (cleaning of teeth) and application of fluoride. I am responsible for payment on all work performed regardless of my insurance coverage. I acknowledge that my questions, if any, about the inquired set forth above have been answered to my satisfaction.

Patient Signature (guardian if minor) Date

Doctor Signature Date