WOODLAKE ORTHODONTICS

Which Woodlake Orthodontics will be your primary location? (Anoka, Burnsville, Lake Elmo, Maple Grove, Midway (St. Paul, Richfield, or Rosemont)

Welcome to our Practice					
First Name:		Last Name:		Middle Initial:	Nickname:
Title:		Gender:		Family Status:	
Birthdate:		Social Security #:		Previous Visit:	
Email Address:			Best time to call:		
Home Phone:	Mobile:	Work:	Work Ext.:	Fax:	Other:
Address:			Address 2:		
City:			State:		Zip Code:
Whom may we thank for referring you to our practice?					
In an emergency, who should be notified? Please enter name and phone numbers below:					

Employment Information		
The following is for)patient, person responsible for payment, both, NA):		
Employer Name:		Phone:
Employer Address:		Address 2:
City:	State:	Zip Code:

Responsible Party Information
Please complete this section if the person responsible for payment is someone other than the patient. (i.e., your spouse is the insured subscriber or the patient is a dependent)
Relationship to patient:

First Name:	Last Name:	Middle Initial:	Nickname:
Title:	Gender:	Family Status:	
Birthdate:	Social Security #:	Driver's License #:	

Email Address:	Best time to call:

Home Phone:	Mobile:	Work:	Work Ext.:	Fax:	Other:

Address:	Address 2:

City:	State:	Zip Code:

Insurance Information

Last Name of Insured:	First Name of Insured:	Middle Initial:
Insured's Birthdate:	ID #:	Group #:
Insured's Address:	Address 2:	
City:	State:	Zip Code:
Insured's Employer Name:		
Employer Address:	Address 2:	
City:	State:	Zip:
Patient's relationship to insured:		
Plan Name:		
Insurance Address:	Address 2:	
City:	State:	Zip Code:
Secondary Insurance		
Last Name of Insured:	First Name of Insured:	Middle Initial:
Insured's Birthdate:	ID #:	Group #:
Insured's Address:	Address 2:	
City:	State:	Zip Code:
Insured's Employer Name:		
Employer Address:	Address 2:	

City:	State:	Zip:
Patient's relationship to insured:		
Plan Name:		
Insurance Address:	Address 2:	
City:	State:	Zip Code:

Dental History

Please answer Yes to any of the following conditions that apply to you.

Periodontal (Gum) Health

Bleeding, swollen, irritated gums	Bad breath
Loose, tipped, shifting teeth	Previous perio/gum disease

Pain/Discomfort

Sensitivity to hot/cold/sweet	Pressure	Broken teeth/fillings
Worn teeth	Dry mouth	Jaw joint (TMJ) pain
Sore muscles (neck, shoulders)	Teeth that irritate tongue, cheek, lip, etc.	

Habits

Thumb sucking	Nail biting	Cheek/lip biting
Chewing on ice/foreign objects	Frequently chew gum	

Function

Grinding/clenching	Jaw joint (TMJ) clicking/popping	Bad bite
Speech impediment	Mouth breathing	Difficulty opening or closing mouth
Difficulty chewing on either side	Difficulty swallowing	

Appearance

Discolored teeth	Worn teeth	Misshaped teeth	Crooked teeth
Spaces	Overbite	Flat teeth	Missing/extra permanent teeth

Sleep Pattern or Conditions

Sleep apnea	Snoring
Daytime drowsiness	Bed wetting (in children)

Comfortability with Dental Treatment

Fear (dentists, needles, drill, etc.)	Anxiety
Previous negative experience(s)	Fear of dental noises

General & Dental Health

Frequent headaches	Frequent sore throats	Jaw fractures, cysts, mouth infections
Brush teeth daily	Floss teeth daily	Numerous fillings
Frequent canker sores or cold sores	Problems with food trapped between teeth	

Have wisdom teeth been removed?

Is there any outstanding dental work to be completed? (i.e. crowns, extractions, cavities, etc. that require treatment as diagnosed by your general dentist)

Previous root canal therapy?

Social

Current/Former Tobaccos Use:
If yes, please indicate frequency and duration:
Alcohol Frequency:

Recreational Drug Frequency:
Please list family history of any conditions marked above:

Where would you rate your smile on a scale of 1-10, with 10 being the highest rating?
Rate where you would like your smile to be on a scale of 1-10, with 10 being the highest rating?

What would you like to change about your smile? (Please answer Yes for all that apply)

Color	Crowding	Bite	Smile makeover
Chipped teeth	Missing teeth	Spaces	

Current dentist name, city, state, and phone number:	
Has the patient had an orthodontic consult or treatment?	If so, when?

Medical History (Write Yes for all that apply)			
Allergies	Anemia	Anesthetic Allergy	Angina Pectoris
Arteriosclerosis	Artificial Heart Valve	Arthritis	Artificial Joints
Aspirin Allergy	Asthma	Blood Disease	Bone Disorders/Bone Loss
Bone fractures/Trauma to face/Jaw	Bruise Easily	Cancer	Chemotherapy
Codeine Allergy	Congenital Heart Lesions	Darvon Allergy	Diabetes
Dizziness	Drug Addiction	Emphysema	Epilepsy
Erythromycin Allergy	Excessive Bleeding	Fainting	Glaucoma
Growth Problems	HIV Positive	HPV	Hay Fever
Head Injuries	Heart Disease/Attack	Heart Murmur	Heart Surgery
Hepatitis	High Blood Pressure	Hormone Therapy	Jaundice
Jaw Joint Pain	Kidney Disease	Large Tonsils	Latex Allergy

Liver Disease	Low Blood Pressure	Mitral Valve Prolapse	Nervous Disorders
Nitrous Allergy	Pacemaker	Penicillin Allergy	Persistent Cough
Persistent Swollen Neck Glands	Phen Fen	Pneumonia	Prosthetic Joints
Psych. Treatment	Radiation Treatment	Respiratory Problems	Stomach Problems
Stroke	Sulfa Allergy	Thyroid Disease	Tonsils/Adenoids Removed
Treated for Emotional Problems	Tuberculosis	Tumors	Ulcers
Venereal Disease	Other		

Women:

Currently Pregnant	Nursing

Do you take an antibiotic premedication for your dental visits?
If yes, please explain:
Are you under the care of a physician?
If yes, please explain:
Physician name, address, and phone number:
Date of Last Physical:
Preferred Pharmacy and phone number:
Have you had a serious illness, operation, or hospitalization in the past 5 years?
If yes, please explain:
Are you takin, or have you recently taken, any prescription or over the counter medications?
Please list any medications you are currently taking, one medication per line:

Please list any medications or substitutes you are allergic to:
Have you ever in the past, or are you currently taking any Bisphosphonates or any other medications for Osteopenia/Osteoporosis or Bone Disease?
If yes, please list the medications:
Have you ever had surgery?
If yes, what type?
I authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions. **I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Patient Motivation from Orthodontic Treatment	
Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (check the words - upper, lower, more, etc.)	
Teeth - If your teeth could be changed, how would you like them to change? Please circle.	
Straighten Front Teeth Upper Lower Both	**Straighten Back Teeth** Upper Lower Both
Move Upper Teeth Forward Backward	**Move Lower Teeth** Forward Backward
Eliminate Spaces Between Teeth Upper Lower Both	**Eliminate Crowding of Teeth** Upper Lower Both
Make Line of Teeth More Level? (Yes or No)	**Other**
Face - If your facial appearance could be changed, what would you change? Please circle.	
Move Upper Lip Forward Backward	**Move Lower Lip** Forward Backward
Show my teeth when I smile Longer Shorter	**Show my gums when I smile** More Less
Make my nose	**Move chin** Forward Backward
Move Chin Left Right	**Reduce the strain when I close my lips in my** Chin Lips Both

When my teeth touch make my lips Closer Together Farther Apart	Get rid of sage under lower jaw
Symptoms - If you want to reduce pain or discomfort, please be specific about its location; circle the right or left side or both if they apply.	
My teeth Left Right Both	**My sinuses** Left Right Both
In front of ears Left Right Both	**Below ears** Left Right Both
Above ears Left Right Both	**In my ears** Left Right Both
My temples Left Right Both	**My eyes** Left Right Both
My neck Left Right Both	**My shoulders** Left Right Both
My jaw joints Left Right Both	**Other**

Patients Under 18			
Height:	Weight:	School:	Grade:
Has patient begun puberty:		If patient is a girl, has menstruation begun:	
If patient is a boy, has their voice changed or have facial hair:			
Has either biological parent ever had orthodontic treatment:			

Financial Policy

We are pleased that you have selected us as your dental care provider.
For your knowledge, our Financial Policy is outlined below.

Promise to Pay. Amounts for dental care services provided to you or your family members may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with an insurance claim; however, insurance is a contract between the policyholder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your full responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments or collection costs. We will provide to you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

Missed Appointment Fee. We may charge to your Account fees for a missed appointment or fees for an appointment cancelled without advance notice of at least 24 hours.

Late Payment Fee. If we do not receive payment in full of your Balance within 30 days of the statement date shown on your Statement, you will be assessed a Late Payment Fee of 2.00% of your unpaid Balance each month. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your Balance.

Returned Payment Fee. If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee, which is currently $30.00 and may be adjusted.

Collection Costs. If we do not receive payment under the terms of this Financial Policy and we refer your Account to a collection agency or an attorney for collection, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extent not prohibited by applicable law.

No Waiver by Us. We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

Credit Reports. We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report to a credit reporting agency information about you that is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the above address.

As used in this Financial Policy, "we," "us," "our" and "Provider" mean the service provider named above. "Services" means any services provided by us. "You," "your" and "Account holder" mean the person responsible for paying for services. Payment for the services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "Account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.

Yes, I agree to the above terms and conditions.

Account Holder's Signature	Print Name:	Date:

No, I am not interested in establishing an account and therefore understand that full payment for dental care services, subject to limitations imposed by my insurance company, if any, is due at the time of appointment.

Account Holder's Signature	Print Name:	Date:

Acknowledgement of Receipts of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Please select one:

I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.
I have read and understand the above information and refuse to sign this HIPAA Disclosure Form.

Authorization to Release Information

This form is used to obtain authorization to release information regarding yourself under the Privacy Act to people other than yourself. You may list multiple people or no one, if you wish.

I understand the above information and authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself. (Answer Yes/No)

Please type the name and relationship of the person(s) you authorize our practice to release information regarding yourself to:

HIPAA Authorization to Use and Disclose PHI for Marketing Purposes

PLEASE READ THIS AUTHORIZATION CAREFULLY. IF YOU CLICK "YES", YOU AGREE TO BE BOUND BY THE TERMS FO THIS AUTHORIZATION. IF YOU DO NOT AGREE, CLICK "NO". CLICKING EITHER BUTTON BELOW CONSTITUTES YOUR ELECTRONIC SIGNATURE.

1. I authorize this dental office and it's Business Associates and Subcontractor Business Associates (collectively, "We" or "Us") to use and disclose my health information ("Health Information") for the purpose of delivering marketing messages to me and requesting feedback about my patient experiences, and suggestions as to how We can improve e-mail0 and/or text message offerings, to the e-mail address and/or mobile telephone number previously provided to Us (the "Authorized Purposes"). I understand that the frequency of these messages may vary.

2. I understand that my Health Information may also include information provided by me or my health plan, or other health care providers, and also other publicly available information. I understand that my Health Information may be considered "Protected Health Information" ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996, and it's implementing regulations (collectively, "HIPAA").

3. I authorized the use and disclosure of any Health Information or PHI by Us for this purpose.

4. I understand that communications transmitted via unencrypted email, text message or over an open network may be inherently insecure, and there is no assurance of confidentiality for information communicated in this manner. I also understand that emails and text messages have inherent privacy risks, especially when access to my computer or mobile device is not password protected.

5. I acknowledge that my signing of this Authorization is voluntary. I understand that I am not required to sign this Authorization, and my decision to sign or not sign will have no effect on my treatment, enrollment or eligibility or payment for benefits.

6. I understand that, once Health Information or PHI has been disclosed pursuant to this Authorization, federal and state privacy laws may no longer protect the information from further disclosure. However, we agree to protect your Health Information and PHI by using and disclosing it only for the Authorized Purposes or as required by law or regulation.

7. I understand that the Authorized Purposes described above may also involve direct or indirect financial remuneration from a third party in connection with the use or disclosure of my Health Information.

8. I understand that I may revoke this Authorization at any time by notifying this dental office at the e-mail address listed at the top of this form; for text messages, by replying "STOP"; or for e-mail messages, by following the instructions in the e-mail to unsubscribe. Standard message and data rates may apply. I also understand that the revocation will not be effective until this dental office receives it but will not affect any actions taken by Heartland Dental in reliance on this Authorization prior to receiving electronic notice via e-mail of the revocation.

9. I understand that I have the right to receive a copy of this Authorization for my records.

10. This Authorization is valid from the date indicated below until the sooner of the date that this dental office or Heartland Dental on behalf of this dental office receives revocation, as described in paragraph 8, above, one year after the below date or as otherwise limited by applicable law.

Date:	Please answer Yes or No:

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

I understand that where appropriate, credit bureau reports may be obtained.