HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET

Name (Last, First): ________________________________ Medicaid ID: ______________ DOB: ______

All necessary dental work completed? Yes ___ No ___ *Patient oral hygiene:* Excellent___ Good___ Poor___
(all dental work must be completed and oral hygiene must be good BEFORE orthodontic treatment is approved)

PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler):

- **Indicate by checkmark next to A or B which criteria you are submitting for review**
- Position the patient's teeth in centric occlusion;
- Record all measurements in the order given and round off to the nearest millimeter (mm);
- ENTER SCORE “0” IF CONDITION IS ABSENT

A.____CONDITIONS 1-4 ARE AUTOMATIC QUALIFIERS (indicate with an “X” if condition is present)

1. **Cleft palate** ______________
2. Deep impinging bite **with** signs of tissue damage, not just touching palate ______________
3. Anterior crossbite **with** gingival recession ______________
4. **Severe traumatic deviation** (i.e., accidents, tumors, etc. attach description) ______________

B.____CONDITIONS 5-13 MUST SCORE 28 POINTS OR MORE TO QUALIFY

5. **Overjet** (one upper central incisor to labial of the most labial lower incisor) mm ____ x 1 = ______________
6. **Overbite** (maxillary central incisor relative to lower anteriors) mm ____ x 1 = ______________
7. Mandibular protrusion (reverse overjet, **“underbite”**) mm ____ x 5 = ______________
8. **Openbite** (measure from a maxillary central incisor to mandibular incisors) mm ____ x 4 = ______________
9. **Ectopic teeth** (excluding third molars, see note below) # teeth _____x 3 = ______________

Note**: If anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score only the most severe condition;* ***do not score both

10. **Anterior crowding of maxilla** (greater than 3.5 mm) if present score __1__x 5 = ______________
11. **Anterior crowding of mandible** (greater than 3.5 mm) if present score __1__x 5 = ______________
12. **Labio-lingual** spread (either measure a displaced tooth from the normal arch form or labial-lingual distance between adjacent anterior teeth) mm ____x 1 = ______________
13. Posterior **crossbite** (1 must be a molar), score only 1 time – if present score __1_ x 4 = ______________

TOTAL SCORE (must score 28 points or more to qualify) ______________

Provider Signature____ Date____________________

Updated 10/24/2016

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date___________________

Patient's name____
Last First Middle

Address ____
Street City Zip

Nickname______________________ Birthdate_______________ Social Security # ____

School___________________________ Sports/Hobbies____

Parent or guardian name____

Whom may we thank for referring you to our office?

☐ Friend/Family ☐ Insurance ☐ Dentist ☐ Pass By ☐ Internet ☐ Other: ___________________

RESPONSIBLE PARTY INFORMATION

Name____
Last First Middle

Residence ____
Street City Zip

Mailing Address____
Street City Zip

How long at this address?______ Home phone_________________________ Work phone __________________________________

Cell/other phone_________________________ Email address____

Previous Address (If less than 3 years) ____

Social Security #_____________________________ Birthdate_________________ Relationship to Patient_______________________

Employer_____________________________________ Occupation____________________ No. years employed ________________

Spouse's Name____ Relationship to Patient _______________________________

Employer_____________________________________ Occupation____________________ No. years employed ________________

Social Security # ________________________________ Birthdate _____________________Work Phone______________________

DENTAL INSURANCE INFORMATION

Insured's Name____ Insured's Social Security #______________________________

Insurance Company_________________________ Group No._________________ Local No. ________________________________

Insurance Co. Address____ Phone No.______________________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name____ Insured's Social Security #_________________________________

Insurance Company_________________________ Group No._________________ Local No. ________________________________

Insurance Co. Address____ Phone No.______________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____

Complete address ____
Street City Zip

Phone ____

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

Parent Signature ____

Updates (date & initial) ____

MEDICAL HISTORY

Physician ______________________________ Date of Last Visit ____________________
Address ______________________________ Phone ____________________
Please circle Yes or No (If Yes, please fill in details)

Yes ☐ No ☐ Are you taking any medication? ____________________
Yes ☐ No ☐ Are you allergic to any medication? ____________________
Yes ☐ No ☐ Do you have a history of a major illness? ____________________
Yes ☐ No ☐ Have you had any operations? ____________________
Yes ☐ No ☐ Have you ever been involved in a serious accident? ____________________
Yes ☐ No ☐ Have you ever smoked or chewed tobacco? ____________________
Yes ☐ No ☐ Have seen a physician in the last 12 months? Why? ____________________
Female Patients only:
Yes ☐ No ☐ Are you pregnant?____________________
Yes ☐ No ☐ Has menstruation started? ____________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	☐	Diabetes	☐	Hepatitis/Liver problems	☐	Pneumonia	☐
Anemia	☐	Dizziness	☐	Herpes	☐	Prolonged Bleeding	☐
Arthritis	☐	Epilepsy	☐	High Blood Pressure	☐	Radiation/Chemotherapy	☐
Asthma or Hayfever	☐	Gastrointestinal Disorders	☐	HIV / Aids	☐	Rheumatic Fever	☐
Bone Disorders	☐	Heart Problems	☐	Kidney problems	☐	Tuberculosis	☐
Congenital Heart Defect	☐	Heart Murmur	☐	Nervous Disorders	☐	Tumor or Cancer	☐

Are there any medical conditions we have not discussed that you feel we should be aware of? ____________________
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DENTAL HISTORY

General Dentist ______________________________ Date of last visit ____________________
What concerns you most about your teeth? ____________________

Yes ☐ No ☐ Are you presently in any dental pain?____________________
Yes ☐ No ☐ Have you ever experienced any unfavorable reaction to dentistry? ____________________
Yes ☐ No ☐ Have your wisdom teeth been removed? ____________________
Yes ☐ No ☐ Have you ever lost or chipped any teeth?____________________
Yes ☐ No ☐ Have there been any injuries to face, mouth, or teeth?____________________
Yes ☐ No ☐ Is any part of your mouth sensitive to temperature? Where? ____________________
Yes ☐ No ☐ Is any part of your mouth sensitive to pressure? Where?____________________
Yes ☐ No ☐ Do your gums bleed when you brush? ____________________
Yes ☐ No ☐ Do you have any type of thumb or tongue habit? ____________________
Yes ☐ No ☐ Are you a mouth breather? ____________________
Yes ☐ No ☐ Have you ever seen an orthodontist? If yes, who and when?____________________
Yes ☐ No ☐ What is your attitude toward receiving orthodontic treatment? ____________________
Yes ☐ No ☐ Has anyone in your family received orthodontic treatment? ____________________
How did they feel about the result?____________________
Yes ☐ No ☐ Do your teeth or jaws ever feel uncomfortable when you awake in the morning?____________________
Yes ☐ No ☐ Are you aware of your jaw clicking or popping? ____________________
Yes ☐ No ☐ Are you aware of clenching your teeth during the day? ____________________
Yes ☐ No ☐ Have you ever been told that you grind your teeth? ____________________
Yes ☐ No ☐ Do you have “tension” headaches?____________________
Yes ☐ No ☐ Have you ever experienced chronic ringing in your ears?____________________
Yes ☐ No ☐ Are you aware that some appointments will be during work hours? ____________________

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize the Orthodontist’s at AllCare Orthodontic Center to perform a complete orthodontic evaluation.

Signature: ______________________________ Date: ____________________

PUBLIC AID PATIENT CARE POLICY

Screening appointment

1. When making the screening appointment, two contacts telephone numbers for patient/parents are required.
2. The screening appointment must ***not*** be disregarded. Any cancellation or re-scheduling of the appointment must be made at least 24 hours before the appointment date. If the screening appointment is failed another appointment there will ***not*** be another made.
3. The screening appointment involves assessing the complexity of the malocclusion by the Salzmann Index criteria requiring 42 points for IDPA acceptance. Those patients that have a severe malocclusion and are near to the required 42 points will have records made for submission for a possible chance of acceptance by IDPA.
4. Patients that definitely do not meet the HLD Index criteria will be told about a standard fee plan and discounts and payment plans that are available to have orthodontic treatment. The patient treatment coordinator has specific instructions and script to sell treatment to these patients.
5. Public aid does not cover treatment involving the primary dentition or mixed dentition. However, some patients will be advised that They may benefit from early treatment to avoid more complicated comprehensive orthodontic treatment in the future.

______
Initial

Fees

1. Fees for orthodontic treatment are as per the IDPA/DentaQuest Guidelines. For all approved cases, each visit is subjected to a ***$10.00*** co-pay, and treatment fee within two years will be covered by IDPA. However, broken, lose and/or lost orthodontic appliances are not covered by IDPA. For all denied cases, the patients and billing parties are responsible for all treatment fee.
2. If preliminary orthodontic treatment is required, these charges are to be paid by the patient/parent (no discount is given). These fees are applicable to all patients, IDPA or self-pay.
3. For those patients that come in for screening and was determined NOT to have enough score to quality BUT still would like to have their cases sent to DenteQuest for IDPA approval, a non-refundable records fee of <***$300.00***> (Ceph, Pano, Photos) will be charged and payment will be due at the records appointment.
4. A limited orthodontic treatment (Phase I) may be initiated when indicated for a separate fee. If preliminary appliances are required (in Limited treatment or Phase I treatment) such as a Headgear, Expender, Face Mask, Lip Bumper, etc., there will be charges to the patient/parents as per the fee schedule. No discounts are given for these charges. **<your practice> provides services only on a pre-pay basis. Payment in full must be received prior to the placement of any appliance.**
5. IDPA covers orthodontic treatment within 24 months. If treatment time is extended due to poor cooperation by the patient, any visit after the 24th month will be subjected to a <***$100.00***> per visit fee. The patient/parents are responsible for the payments.
6. Patients and their responsible party are responsible to keep their IDPA card active. Any expired coverage by IDPA will require one of the following: (a) discontinuation of treatment and removal of **ALL** orthodontic appliances including braces; retainers will not be placed **OR** (b) continuation of treatment with patient/parent responsible for the remaining of unpaid balance by IDPA.

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Initials

Appointments

1. Appointments for IDPA patients are available on **<certain day>** only. Patients are seen only during **<certain time>.** The last appointments made for **<end time>** are only for minor adjustments.
2. If an emergency occurs, these patients can be seen at other times only to eliminate the emergency. The appliances will not be repaired or adjusted. A separate appointment will be made for the repair. At the repair appointment, the applicable fees will be charged and must be paid for at the time of the repair.
3. Failure to keep appointments as scheduled or follow instructions will initiate dismissal procedures for discontinuation of orthodontic treatment. After THREE failed appointments, treatment will be terminated. If the patient is late for their scheduled appointment without properly notifying the office, it will be considered a failed appointment.
4. With the third failed appointment, the orthodontic treatment is discontinued. The proper notifications will be sent. The patient will be seen for emergency treatment only for 30 days in which the parent can choose to continue treatment with another orthodontist (dental practitioner) or the appliances will be removed.

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Initials

Repairs/Replacement

1. As explained above, repairs are only made on specific repair appointments. Only two repairs are allowed during the treatment. Any repairs required above two times will be charged as per the fee schedule.
2. Patient must follow instructions in oral hygiene care and appliance maintenance. Negligence can lead to broken appliances.
3. There will be a charge of <***$50.00***> per loose or broken bracket.
4. For a broken or lost retainer there will be a charge of <**$250.00 - 300.00**> per retainer.
5. Broken appliances such as headgears, expanders, face mask, bands, biteplates, etc., will have applicable replacement fees.

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Initials

___________________________	________________________________	___________________________________	
Print Name of Patient	Print Name of Parent/Legal Guardian	Print Name of Orthodontist/Witness	
___________________________	________________________________	___________________________________	
Parent Signature	Date	Orthodontist/Witness Signature	Date

PRIVACY NOTICE

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.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);

- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;

- Internally, to all staff members who have any role in your treatment;

- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;

- To your family and close friends involved in your treatment and/or,

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information.

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

____
Patients Signature

____
Print Name

____
Date