AllCare Orthodontic Center
Screening Sheet

Ver 2.2 05/31/2018

Patient Name (First, Last): _____

Birthdate (mm/dd/yyyy): ___/___/____

Gender: ☐ Male ☐ Female

Screening Info

Malocclusion classification: ☐ Class I ☐ Class II ☐ Class III

☐ Class II Div 1 ☐ Class II Div 2

Oral hygiene: ☐ Poor ☐ Average ☐ Good

Dentition: ☐ Early ☐ Early Mixed ☐ Late Mixed ☐ Adult

Overjet: _____ mm _____ % Overbite: _____ mm

Crossbite: ☐ Anterior ☐ Posterior ☐ Unilateral ☐ Bilateral

Crowding upper: _____ mm Crowding lower: _____ mm

Other significant findings: _____

_____

_____

Treatment recommended ? ☐ Yes ☐ No ☐ Observe

☐ Extraction
☐ No Extraction
☐ Both
☐ Surgery

Appliance Needed? ☐ Yes ☐ No Appliance Name: _____

Treatment Time: _____

A B C

ADULT PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Previous Address (If less than 3 years) _____

Cell Phone_____ Birthdate_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Whom may we thank for referring you to our office?

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

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.

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? _____
_____

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: _____

AllCare Orthodontic Center Initial Examination Consent Form

Thank you for choosing AllCare Orthodontic Center as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our financial policy.

We accept payments in CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, CHASE HEALTH ADVANTAGE and CARE CREDIT.

- When mailing a payment, the payment is due to the following office location:

  AllCare Orthodontic Center
  47 W. Polk Street, Suite 251
  Chicago, IL 60605

- Prompt payment is essential. We must receive your payment on or before the due date.
- Payment options are not based on treatment time. In some cases, contracts may extend past treatment time. Payments on contracts are to continue until payment in full.
- Contracts are not subject to penalties if paid in full early.

CONTRACT AGREEMENT

- As a courtesy we offer a 10 day grace period from your due date. After the 10 days, an automatic $10 late fee is applied.
- If a payment is returned unpaid there will be a $25 returned check fee. This fee is due immediately and if it is not paid within 10 days, is subject to a $10 late fee.
- We reserve the right to charge a 10% finance charge.
- Your account and account information must be kept current at all times. Should you change your address, telephone number or job, please notify us so we can keep your information current. This will eliminate any disruption on your contract. If you need to make any changes on your contract or payment please contact us at **(312) 804-8304.**
- Billing statements are only sent out on past due accounts at the beginning of each month.

_____**Initials**

CANCELLATION POLICY

- A 24 hour cancellation notice is appreciated. If the appointment is not canceled or re-scheduled within 24 hours prior to your appointment, there is a no-show fee of $30 for that missed appointment. Please help us serve you better by keeping scheduled appointments.

_____**Initials**

OFFICE POLICY ON PAST DUE ACCOUNTS

- Accounts are monitored by our financial department and at any time we reserve the right to cancel an appointment if an account should become more than 60 days past due.
- Our financial treatment policy will extend progressive treatment up to 60 days past due. Once the account is defaulted by 90 days the discontinuation of services will be started.

_____**Initials**

MINOR

- The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.
- For unaccompanied minors, current balance is due at time of check in. Non-emergency appointments will be denied if balance un-paid.

_____**Initials**

INSURANCE AGREEMENT

- Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers routinely stall, deny, and reduce payments. To that end, our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement, while reducing the time in which they pay.
- We will gladly bill your insurance as a courtesy; however, we do not submit automatic disputes if for any reason your claim is denied.
- You are responsible for getting proper referral in advance of your appointment.
- Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due as per your contracted agreement. In the event your policy will terminate, your co-pays will be increased to our usual and customary rates.
- If your insurance changes or terminates we request that you notify our insurance department, so we can promptly update your account and discuss any possible changes.

_____**Initials**

AUTHORIZATION FOR SIGNATURE ON FILE

Release of information/Financial Responsibility/Assignment of Benefit: I hereby authorize the office of AllCare Orthodontic Center, to affix my name to any all claims or documents as related to any and all health benefits due to me and my dependents through my employment. I hereby authorize payment of orthodontic benefits otherwise payable to me, directly to AllCare Orthodontic Center. I have read, understand and agree to the terms and conditions of this document. To the extent permitted under applicable law, I authorize release of any information related to insurance claims.

_____**Initials**

_____
PATIENT NAME

_____ _____
PATIENT SIGNATURE DATE

_____
PARENT/GUARDIAN NAME (IF PATIENT IS UNDER 18)

_____ _____
PARRENT/GUARDIAN 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