CAPPS & WOODS ORTHODONTICS
WELCOME TO OUR OFFICE

CHILD PATIENT INFORMATION

Today's Date:_____

Name:_____ Prefer to be called:_____ Sex:_____

Age:_____ Birthdate:_____ Patient's interests:_____

Patient resides with: Mother Father Both Other:_____ Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

Patient's Dentist:_____ School:_____Grade:_____

Describe your child's orthodontic problem:_____

Has any member of the family had orthodontic treatment? If so, by whom?_____

Please list names of other family members treated in our office_____

Whom may we thank for referring you to our office? (Circle all that apply)

- Word of mouth Social media Doctor: _____
- Internet search Drive-by Other person: _____

Who is accompanying patient today?_____

Parents and Account Information

Parent's Marital Status: Married Separated Divorced Widowed

	FATHER	MOTHER
Name:	_____	_____
Date of birth:	_____	_____
Address: (if different than above)	_____	_____
Phone:(if different than above)	_____	_____
Cell Phone:	_____	_____
E-mail address:	_____	_____
Employer's name:	_____	_____
Business phone:	_____	_____
Occupation:	_____	_____
Person responsible for account:	_____	_____

If other than parent:

Name: _____ Address: _____ Phone: _____

In case of an emergency, please provide name, address and phone number of your nearest relative:

Name: _____ Address:_____ Phone: _____

INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee):_____

Date of birth:_____ Social Security#_____-_____-_____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential.

Physician's Name: _____ Address: _____ Phone: _____
Has your child experienced any health problems? No Yes Explain: _____
Any major change in your child's health recently? No Yes Explain: _____
Is your child currently under a physician's care? No Yes Explain: _____
Is your child currently taking any medications? No Yes Explain: _____
Is your child allergic to any medications? No Yes Explain: _____
Has your child received a blood transfusion? No Yes Explain: _____
Have your child's tonsils or adenoids been removed? No Yes Explain: _____
Please check if your child has had any of the following conditions:

Heart Murmur…….	No	Yes	Hepatitis…….	No	Yes	Emotional Problems……..	No	Yes
Heart Surgery……..	No	Yes	Diabetes…….	No	Yes	Frequent Headaches……..	No	Yes
Rheumatic Fever…….	No	Yes	Kidney Disease……..	No	Yes	Nervous/Anxious…..……	No	Yes
Endocrine disorders…….	No	Yes	Liver Disease…….	No	Yes	Cancer……..……..	No	Yes
Prolonged Bleeding…….	No	Yes	Tuberculosis……..	No	Yes	Bone Disorders……..	No	Yes
Anemia…….....	No	Yes	Bronchitis……..	No	Yes	Growth Disorders……..	No	Yes
Blood Disease……..	No	Yes	Asthma…….....	No	Yes	Mouth Breather…….	No	Yes
Developmental Disorder..	No	Yes	Epilepsy…….	No	Yes	Herpes (Fever Blisters)….	No	Yes
Hives/Rash…..……..	No	Yes	Fainting……..	No	Yes	Tonsillitis……	No	Yes

Has patient ever had an unusual reaction to any drug such as penicillin, antibiotics, or aspirin? No Yes
If so, please explain:_____
Is there any other condition or problem that you think we should know about? _____

Growth Information for Patients:
Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in selection of treatment alternatives.
Has your son or daughter reached puberty? No Yes
Girls- Has she started menstruation? No Yes When? _____
Boys- Has his voice changed? No Yes When? _____
Father's Height:_____ Mother's Height:_____ Patient Adopted: No Yes
Names and Birthdates of patient's brothers and sisters: _____
Dental checkups: 2 times a year 1 time a year Only if problem exists Never Date of Last Visit:_____
Is there any unfinished care to be completed with your child's dentist? No Yes Explain: _____
Is your child frightened about dental treatment? No Yes Explain: _____
Has your child had an unpleasant experience in the dental office? No Yes Explain: _____
Has your child had any facial or dental injuries? No Yes Explain: _____
Is there any history of thumb or finger sucking? No Yes Explain: _____
Does your child play any musical instruments? No Yes Explain: _____
Has your child consulted an orthodontist previously? No Yes Explain: _____
Have teeth (either primary or permanent) been removed? No Yes Explain: _____
Has your child had any previous orthodontic treatment? No Yes Explain: _____
Are you satisfied with prior treatment? No Yes Explain: _____
Any changes in your child's bite or dental alignment recently? No Yes Explain: _____

Please check if there is a history of:
Clenching teeth Muscular soreness around head & neck Jaw joint soreness Jaw joint popping
Grinding teeth Headaches (more than normal) Jaw joint clicking Ringing in the ears
Speech problems (if so what sounds _____) Mouth breathing Awake_____ Asleep _____
Snoring Smoking
Is there any other information which may be helpful?_____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial report.

_____ _____
Parent Signature **Date** **Reviewed by**

CAPPS & WOODS ORTHODONTICS
AIRWAY QUESTIONNAIRE

While Sleeping Does Your Child.....	Yes	No	I don't know
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have 'heavy' or loud breathing?			
Have trouble breathing or struggle to breathe?			
Have you ever seen your child stop breathing while sleeping?			
Does your child....			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Wake up feeling un-refreshed in the morning?			
Have problems with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
This child often.....			
Does not seem to listen when spoken to directly			
Has difficulty organizing tasks			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Is "on the go" or often acts as if "driven by a motor"			
Interrupts or intrudes on others (E.g. butts into conversations or games)			

Total number of **YES** responses _____

If **eight or more** statements are answered with "**yes**," consider referring for sleep evaluation.

CAPPS & WOODS ORTHODONTICS
OFFICE POLICIES

Financials:

- It is agreed that if your account becomes delinquent for more than 90 days we will no longer be able to see any patient for their regular visits until your account is brought up to date.
- If you opt to take advantage of our in house, interest free financing, we do require you set up a monthly auto draft using the card of your choice.
- You may pay more toward your down payment if you would like to reduce your monthly payment.
- Insurance responsibility is an estimate given by your insurance company's plan benefits. Responsible Party/Patient is responsible for payment of insurance portion upon discontinued coverage or insurance claim denial.
- There is NO interest charged and NO additional charges will be applied IF treatment extends past the given estimated treatment time unless otherwise discussed.
- We wish to stress that the frequency of office visits has no bearing on the monthly payment and thus, the monthly payment schedule does NOT correspond to the number or frequency of appointments, but rather to the total cost paid out over the approximate duration of treatment. The payment schedule is merely a convenient way to meet your financial obligation.

Any additional fees would consist of:

- Non-payment from your insurance provider.
- Excessive orthodontic appliance breakage. In order to keep treatment on track, a fee of $25 will be charged for each subsequent breakage after 5 broken brackets/bands/wires/appliances.
- Replacement of lost or broken retainers. Fees will vary depending on the type of retainer that is required. ($235 and up per retainer)
- Please be aware, there will be a $35.00 charge for any checks returned for insufficient funds.
- An additional charge of $350.00 per arch is required for clear/ceramic brackets.

Our fee includes all appliances, all appointments, any records taken during treatment, upper and lower retainers at the end of treatment, and 12 months of retainer checks after braces/appliances have been removed. An office visit fee of $65 will be charged after the 12 month period for routine retainer checks. General dental care, six months exams, and restorative treatment for cavities are the responsibility of your general dentist.

Appointments:

- Regular adjustment visits will be scheduled approximately every 6-12 weeks.
- If the patient is experiencing a true orthodontic emergency we will be available for scheduled comfort care appointments as a courtesy to you.
- We will do our best to accommodate before and after school appointments. However, due to appointment type, length, or availability these prime appointments are not always available. With this in mind we do provide school and work excuses for each visit.
- You are more than welcome to go back to the clinic area with your child during their appointments. However, in most cases, we encourage that you to remain in the lobby. This helps your son/daughters learn to trust our staff and the doctors if they are anxious in the early stages of his/her treatment. If you have any concerns Dr. Capps or Dr. Woods would be more than happy to discuss them at any time.

I, as the responsible party for this account, certify that I have read this agreement and that all diagnostic materials and treatment alternatives have been explained to me. I also allow the use of this patient's diagnostic records for research or education purposes.

_____ _____

Signature of Responsible Party **Date**

WE LOOK FORWARD TO HELPING OUR PATIENTS ACHIEVE A GREAT ORTHODONTIC RESULT!
On behalf of everyone here at Capps and Woods Orthodontics, we thank you in advance!

Capps and Woods Orthodontics

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable laws. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change the Notice and make a new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations: For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patient Rights sections of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Persons Involved In Care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity of emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Patients name _____ Relationship to Patient _____

Signature _____ Date _____