Parker Orthodontics
Justin Parker DDS, MS, PC

Name:_____ Date: _____
Patient Address: _____
Home #:_____ Cell #:_____Cell Carrier:_____ E-mail:_____
Patient Birthdate: _____ Age: _____ Sex : _____ Race:_____
School/ Employer: _____ Position: _____
Whom may we thank for referring you to us? _____ Present Dentist: _____
Reason for consultation: _____

Primary Mother: ___ Father: ___ Step Parent: ___ Self: ___ Other (Specify): _____
Responsible Party: _____ Telephone: _____
Address: _____ SSN: _____
Employer: _____ Telephone: _____

Secondary Mother: ___ Father: ___ Step Parent: ___ Self: ___ Other (Specify): _____
Responsible Party: _____ Telephone: _____
Address: _____ SSN: _____
Employer: _____ Telephone: _____

Insurance Information

Name of **primary** orthodontic insurance: _____Phone: _____
Name of policy holder: _____Policy holder's birthdate: _____
Policy id # or SSN: _____ Mother: ___ Father: ___ Step Parent: ___ Self: ___ Other (Specify): _____
Name of **secondary** orthodontic insurance: _____Phone: _____
Name of policy holder: _____ Policy holders birthdate: _____
Policy id # or SSN: _____ Mother: ___ Father: ___ Step Parent: ___ Self: ___ Other (Specify): _____

Health Information

Any disease, problems, or allergies? _____
Current medications?_____
Do you take Boniva,Actonel, Fosamax or have you been diagnosed with osteoporosis? _____
Female: Have you started menstruating? _____ At what age? _____
Have wisdom teeth been extract: _____Any face, mouth or teeth injuries?_____
Does patient breath through the mouth while awake or asleep? _____
Do gums bleed when brushed/ flossed? _____ Are there any missing or extra teeth? _____
Has an orthodontist been previously consulted? _____ Any previous orthodontic Treatment? _____
Have tonsils or adenoids been removed? _____ Any other Questions? _____
Names and ages of siblings: _____

Circle the following

Aids	Y/N	Allergies	Y/N	Anemia	Y/N	Arthritis	Y/N	Aspirn	Y/N
Asthma	Y/N	Autoimmune	Y/N	Bone Disorders	Y/N	Bulimia	Y/N	Cancer	Y/N
Cerebral Palsy	Y/N	Chest Pains	Y/N	Chronic Neck Pain	Y/N	Clicking of Jaw	Y/N	Cold sores/herpes	Y/N
Diabetes	Y/N	Downs Syndrome	Y/N	Drug Allergies	Y/N	Endocrine Problems	Y/N	Emotional Disorders	Y/N
Epilepsy	Y/N	Fainting/Dizziness	Y/N	Glaucoma	Y/N	Headaches	Y/N	Heart Condition	Y/N
Hepatitis	Y/N	High Blood Pressure	Y/N	Immune Problems	Y/N	Kidney Problems	Y/N	Low Blood Pressure	Y/N
Mouth Breathing	Y/N	Muscular Disorders	Y/N	Nervous Disorders	Y/N	Organ Transplant	Y/N	Painful Chewing	Y/N
Periodontal Problems	Y/N	Pneumonia	Y/N	Pregnant	Y/N	Prolonged Bleeding	Y/N	Rheumatic Fever	Y/N
Scoliosis	Y/N	Seizures	Y/N	Sicca	Y/N	Speech Problems	Y/N	TMJ Problems	Y/N
Tooth Grinding	Y/N	Tuberculosis	Y/N	Venereal Disease	Y/N				

Signature _____ Relationship to patient _____ Date _____

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ACKNOWLEDGEMENT & INFORMED CONSENT TO TREAT

I have received a copy of Justin Parker D.D.S., M.S. Informed Consent via utahsmiles.com or in office and know that a hard copy is available upon my request. I have carefully read through (pages 1-7) and consent and fully understand the treatment considerations and risks presented in this form. If you desire additional information on any of the points covered, please ask for clarification. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I acknowledge that I have discussed this form with the undersigned orthodontist and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment.

I also authorize the orthodontist to provide my health care information to other health care providers including, but not limited to, radiographs (x-rays), reports, charts, medical history, photographs, findings, models or impressions of teeth, prescriptions, diagnosis, billing, and other treatment records in my doctor's possession.

I understand that use of my medical records my result in disclosure of my "individually identifiable health information" as defined by the Health Insurance portability and Accountability Act ("HIPPA"). I hereby consent to the disclosure(s) as set forth above. I will not, nor shall anyone on my behalf seek legal, equitable or monetary damages or remedies for such disclosure. I acknowledge that use of my medical records is without compensation and that I will not nor shall anyone on my behalf have any right of approval, claim of compensation, or seek or obtain legal, equitable or monetary damages or remedies arising out of any use such that comply with the terms of this Consent.

If an exposure incident should occur, I consent to a test for determination of infectious disease passed to Parker Orthodontic employees.

A photostatic copy of this Consent shall be considered as effective and valid as an original. **I understand that my treatment fee covers only treatment provided by the orthodontist, and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.** I have carefully read the above material and consent to treatment by Justin Parker D.D.S., M.S., P.C., and his staff for the correction of the orthodontic consideration of my children or myself.

Responsible Party(over 18) _____ Date _____

Office Staff _____ Date _____

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment and to the above doctor, and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor for the above individual. I fully understand all of the risks associated with the treatment.

Responsible Party(over 18) _____ Date _____

PERMISSION TO USE RECORDS FOR STUDY & RESEARCH

I hereby give my permission for the use of orthodontic records, including photographs, made in the process or examinations, treatment, and retention for purposes of professional consultations, research, education and training of other professionals and colleagues. I will allow Dr. Justin Parker D.D.S., M.S., P.C. the full use of all x-rays, photographs, molds, other diagnostics and treatment material.

I have the legal authority to sign this on behalf of:

Name of Patient _____

Responsible Party(over 18) _____ Date _____

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CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing.

I have received a copy of Justin Parker D.D.S., M.S. Notice of Privacy Practices via utahsmiles.com or in office and know that a hard copy is available upon my request. I have carefully read through (pages 1-3), and hereby give consent for Justin Parker D.D.S., M.S. to use my personal health information for treatment, payment, and healthcare operations.

Patient's Name (please print) _____

Signature _____ Date _____

If this is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

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Understanding Insurance

How does orthodontic insurance work?
There are different agreements between carriers and their subscribers, and each contract provides a different benefit. However, orthodontic insurance generally differs from regular dental insurance in that each insured individual usually has a lifetime maximum benefit for orthodontic services. This benefit is paid as a percentage of the orthodontic fee (diagnostic records, initial fee, monthly payments, etc.) until the benefit maximum has been reached. Charges for lost or broken appliances may not be covered by insurance.

How does this office assist you with insurance?
We will gladly assist you in submitting initial insurance claims pertaining to charges for care rendered in our office. However, please be aware that our primary financial relationship is with our patients or their families and not with their respective insurance companies. Financial arrangements can be made based on your estimated insurance benefit; however, any outstanding insurance claims not paid are the responsibility of the patient or the patient's family.

Your Responsibility

Initial:
_____ Know what your benefits are before treatment starts. If you are not sure, contact your insurance company so that you know exactly how much you can expect to be paid and when to expect payment.

_____ If you would like our office to submit claims, we ask that you provide us with your group number and the name, address and telephone number of your insurance carrier.

_____ If your company requires verification of continuing treatment, or provides a form for verification of continuing treatment, we will gladly submit the appropriate information.

_____ For medical reimbursement accounts, also known as Flex Accounts, you may use a copy of your cancelled check or a receipt of payment requested from our office.

In the event I change or lose my insurance I understand it is my responsibility to provide new insurance information or set up financial arrangements within 15 days of any change. I understand any unpaid Insurance Balance for any reason is my responsibility.

Responsible Party Signature_____ Date _____

Witnessed By_____ Date _____