

**Patient Information**

**Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Patient SSN : \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_  
 The best way to contact me is on my:  Work Phone  Cell Phone  Text Message  Email  
 Gender:  Male  Female Marital Status:  Single  Married  Widowed  Separated  Divorced  
 If you are a student, please list your school: \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_  
 If you have a dentist, please list your dental provider: \_\_\_\_\_

**Employer**

Patient's Employer: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

**Spouse**

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_

**Emergency Contact**

Name of Emergency Contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_

**Parent or Guardian Information:** *If the patient is a child.*

**Parent/Guardian 1:** \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_

The best way to contact me is on my:  Work Phone  Cell Phone  Text  Email  
 Birthdate: \_\_\_\_\_ SSN : \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Check the appropriate box:  Single  Married  Widowed  Separated  Divorced

**Parent/Guardian 2:** \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_

The best way to contact me is on my:  Work Phone  Cell Phone  Text  Email  
 Birthdate: \_\_\_\_\_ SSN : \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Check the appropriate box:  Single  Married  Widowed  Separated  Divorced

**Person Responsible for Account**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_

The best way to contact me is on my:  Work Phone  Cell Phone  Text  Email  
 Birthdate: \_\_\_\_\_ SSN : \_\_\_\_\_ Driver's License #: \_\_\_\_\_

## Insurance Information

Do you have orthodontic coverage?  Yes  No

Name of Insured: \_\_\_\_\_ Birth date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

Name of employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group No: \_\_\_\_\_ ID No: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_ Zip: \_\_\_\_\_

Ins. Co. Phone: \_\_\_\_\_

Do you have any additional insurance?  Yes  No *If yes, please complete the following.*

Name of Insured: \_\_\_\_\_ Birth date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

Name of employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group No: \_\_\_\_\_ ID No: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_ Zip: \_\_\_\_\_

Ins. Co. Phone: \_\_\_\_\_

## Dental Health History

What are the main concerns that you would like orthodontics to accomplish?

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Have you ever had or been evaluated for orthodontics treatment?  Yes  No

Have you ever had a serious or difficult problem associated with any previous dental work?  Yes  No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No

Do your gums ever bleed?  Yes  No

Have you ever had an injury to your?  Mouth  Teeth  Chin

Do you generally breathe through your mouth?  Yes  No

If yes, please select when:  While Awake  While Asleep

Do you have any missing or extra permanent teeth?  Yes  No

Have you ever taken Phen-Fen? (aka: Redux and Pondimin)  Yes  No If yes, when? Date: \_\_\_\_\_

Do you smoke or use tobacco in any form?  Yes  No

## Medical Health History

Do you have a personal physician?  Yes  No Date of last visit? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Practice Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_ Zip: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No If yes, please explain: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Please list any medications you are currently taking:

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**For Women:**

- Are you taking birth control?       Yes    No
- Are you pregnant?                     Yes    No    Uncertain      Week #: \_\_\_\_\_
- Are you nursing?                       Yes    No

**Have you ever had any of the following disease or medical problems? Please check appropriate box.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding              | <input type="checkbox"/> Fever Blister / Herpes      | <input type="checkbox"/> Psychiatric Problem          |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Radiation Therapy            |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Hearing or Vision Impaired  | <input type="checkbox"/> Respiratory Problems         |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Heart Attack / Stroke       | <input type="checkbox"/> Rheumatic / Scarlet Fever    |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Shingles                     |
| <input type="checkbox"/> Blood Transfusion              | <input type="checkbox"/> Heart Surgery / Pacemaker   | <input type="checkbox"/> Sickle Cell Disease / Traits |
| <input type="checkbox"/> Cancer or Chemotherapy         | <input type="checkbox"/> Hemophilia                  | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Congenital Heart Defect        | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Thyroid Problem              |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> High or Low Blood Pressure  | <input type="checkbox"/> Tuberculosis (TB)            |
| <input type="checkbox"/> Drug or Alcohol Abuse          | <input type="checkbox"/> HIV+ / AIDS                 | <input type="checkbox"/> Ulcers / Colitis             |
| <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Kidney Problems or Diseases | <input type="checkbox"/> Venereal Disease             |
| <input type="checkbox"/> Epilepsy, Seizures or Fainting | <input type="checkbox"/> Mitral Valve Prolapse       |   |

Please list any other serious medical condition(s) that you have ever had:

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**Are you allergic to any of the following? Please check appropriate box.**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Latex                  | <input type="checkbox"/> Plastic            |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Iodine                 | <input type="checkbox"/> Codeine            |
| <input type="checkbox"/> Sulfur Drugs | <input type="checkbox"/> Penicillin             | <input type="checkbox"/> Dental Anesthetics |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Any Metals or Plastics | <input type="checkbox"/> Other              |

Please list any other drugs or materials that you are allergic to:

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature

Date

If this office accepts insurance, I understand that I am



This office reserves the right to verify the credit status of potential patients and or the parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Text and Email Policy

Westrock Orthodontics can email and/or text you appointment reminders and general information about our services. If you would like to receive communications via email or text in the future, please read and sign the consent attached below.

#### Consent to Email and/or Text Message for Appointment Reminders and Other Communications:

You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but chargers from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

Patient Name \_\_\_\_\_ Guardian Name (if patient is a minor) \_\_\_\_\_

Communication Preference:                       Text     Email

Signature \_\_\_\_\_ Date \_\_\_\_\_

### MISSOURI Patients ONLY: Free Service Disclosure

If you are receiving a free service in response to an advertisement, you have the right to refuse to pay, cancel payment for or be reimbursed for any other service performed as a result of and within 72 hours of the free service UNLESS the other service is requested by you at the time you seek the free offer.

By signing the orthodontic treatment contract, I understand that I am requesting a service and I no longer have the right to refuse to pay, cancel payment for or be reimbursed for any other service performed as a result of and within 72 hours of the free service.

Signature \_\_\_\_\_

Date \_\_\_\_\_



## Notice of Privacy Practices and Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

*Please, list below any person who can receive PHI (Protected Health Information) on this patient.*

Name	Relationship	Treatment Info.		Ledger	
		Yes	No	Yes	No
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No
_____	_____	Yes	No	Yes	No

**OFFICE USE ONLY** I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

## Non-Discrimination Policy

### DISCRIMINATION IS AGAINST THE LAW

Rock Dental Brands complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Rock Dental Brands does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Rock Dental Brands:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Paul D. McNiel, Chief Compliance Officer.

If you believe that Rock Dental Brands has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Paul D. McNiel, Chief Compliance Officer  
610 Clinton Ave. Little Rock, AR. 72201  
501-259-8331  
paul.mcniel@rockdentalbrands.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Paul D. McNiel, Director of Dental Operations is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**By signing below, I agree that I have read and understand Rock Dental Brands' Non-Discrimination Policy.**

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Signature

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Date

Translation services are available in the following languages:

<p><b>አማርኛ</b> ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-844-648-5669.</p> <p><b>العربية</b> ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-648-844-1 رقم</p> <p><b>中文</b> 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-844-648-5669.</p> <p><b>Oroomiffa</b> XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-648-5669.</p> <p><b>فارسی</b> توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-844-648-844-5669 تماس بگیرید</p> <p><b>Français</b> ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-648-5669.</p> <p><b>Deutsche</b> ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-648-5669.</p> <p><b>ગુજરાતી</b> સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-648-5669.</p> <p><b>हिंदी</b> ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-648-5669.</p> <p><b>Hmong</b> LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-648-5669.</p> <p><b>日本語</b> 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-648-5669。</p>	<p><b>한국어</b> 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-648-5669.</p> <p><b>ລາວ</b> ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອຂັດພາສາ, ໂດຍບໍ່ຄ່າ ຈຳນວນ ພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-648-5669</p> <p><b>Marshallese</b> LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbal in jipañ ilo kajin ñe am ejjeļok wōñāñ. Kaalok 1-844-648-5669.</p> <p><b>Pennsylvania Dutch</b> Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: Call 1-844-648-5669.</p> <p><b>português</b> ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-844-648-5669.</p> <p><b>русский</b> ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-648-5669.</p> <p><b>Srpsko-hrvatski</b> OBAVJEŠTENJE: Ako govorite srpskohrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-648-5669.</p> <p><b>Español</b> ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-648-5669.</p> <p><b>pilipino</b> PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-648-5669.</p> <p><b>Tiếng Việt</b> CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-648-5669.</p>
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