WELCOME TO OUR ORTHODONTIC OFFICE

ARTHUR L. KAPIT, D.D.S., M.Sc.D., P.A.

PATIENT INFORMATION

Patient Name: _____Today's Date _____

Sex ___ Age____ Date of Birth _____ Home Phone# _____ School _____Grade____

Address _____

Street City State Zip

E-MAIL ADDRESS (Needed to Confirm Appointments)_____

CHILD'S HEALTH INFORMATION

Dentist 's Name: _____Address: _____Phone# _____

Has child ever had any complications following dental treatment? ____yes ____no

If yes please explain:_____

Physician's Name: _____Address: _____Phone# _____

Has child been admitted to a hospital or needed emergency care during the past year? ____yes ____no

If yes please explain: _____

Is child now under the care of a physician? ____yes ____no If yes please explain: _____

Is child now taking any medication? ____yes ____no If yes please explain: _____

Please list any behavioral or developmental disorders _____

Has child ever had any of the following? Please check those that apply:

___AIDS or HIV positive	___Blood/Bleeding disorder	___Heart Disease/Surgery	___**Eye Disease**
___**Allergies: Sulfa Drugs**	___Cancer	___Heart Murmur/Rheum. Fever	___Radiation/Chemotherapy
___Allergies: _____	___Diabetes	___Stomach Problems/Ulcer	___Mental/Nervous Disorder
___Dizziness/Fainting	___Hepatitis (Liver Disease)	___Tuberculosis	___**Asthma/Resp. Disease**
___Anemia	___Ear Disease	___High Blood Pressure	___Tumors/Growth
___Arthritis/Joint Disease	___Epilepsy/Seizures	___Kidney Disease	___Glandular/Hormonal Dis.

Does child have any health problems that need further clarification or any other contributory family medical history? _____yes ____no

If yes please explain: _____

Emergency contact other than child's parents: Name_____Phone#_____Relationship_____

ORTHODONTIC HISTORY (ALL SPACES MUST BE FILLED IN – WRITE n/a IF NOT APPLICABLE)

Who recommended us to you? _____

Chief complaint (your purpose for seeking treatment) _____

Has your child seen another orthodontist? ____yes ____no If yes, who? _____

Has any member of your family had or been treated for an orthodontic problem? _____

If a musical instrument is played, what kind? _____

Gingival infection or treatments? _____Traumatic injury to teeth? _____

Does your child grind their teeth? ____yes ____no ____Day ____Night

Any finger or tongue habits? _____ Age stopped _____

Child's attitude toward braces: ____Good ____Bad ____Indifferent

Please list any other family members who are patients of this office _____

Siblings in orthodontic treatment _____

PARENT'S INFORMATION

Who will pay this account?_____ Relationship to patient _____

Mother: Full Name_____ FATHER: Full Name_____

Address (if diff from child) _____ Address (if diff from child) _____

City _____State_____Zip _____ City _____State_____Zip _____

Phone: Home _____Work_____ Phone: Home _____Work_____

Occupation _____ Occupation_____

Employer _____ Employer _____

Work address _____ Work address _____

City _____St _____ Zip _____ City _____St _____ Zip _____

Mother's Social Security # _____ Father's Social Security # _____

Driver's license # _____ Driver's license # _____

Parent's marital status: ____Married ____Separated ____Divorced ____Widowed ____Single Custodial parent

DENTAL INSURANCE INFORMATION

Are you aware of the extent of your insurance coverage for orthodontics? _____

Primary: Name of insured: _____is insured a patient? _____yes _____no

Insured's birth date: _____ ID#_____Group # _____

Insured's address: _____
Street City State Zip Code

Insured's Employer Name _____

Address_____
Street City State Zip Code

Patient's relationship to insured: _____Self ____ Child ____ Other _____

Insurance plan name and address _____Ins. Co. phone# _____

Secondary: Name of insured: _____is insured a patient? _____yes _____no

Insured's birth date: _____ ID#_____Group # _____

Insured's address: _____
Street City State Zip Code

Insured's Employer Name _____

Address_____
Street City State Zip Code

Patient's relationship to insured: _____Self ____ Child ____ Other _____

Insurance plan name and address _____Ins. Co. phone# _____

AGREEMENT FOR DENTAL SERVICES

1. The parent/legal guardian or guarantor hereby retains Dr. Arthur L. Kapit to render orthodontic services to and for your child's benefit.
2. The parent/legal guardian or guarantor hereby agrees to pay for all the bills and charges for services provided promptly. The charges are due at the time service is rendered.
3. The parent/legal guardian or guarantor acknowledges that he/she is responsible for all charges incurred in the rendering of dental services, regardless of what type of insurance he/she carries. Any action by this office to process applications for insurance or other benefits on your behalf will not relieve you of the obligation to pay the bill. The parent/legal guardian or guarantor further understands that any failure by the insurance company or other provider of benefits to pay for all or part of your bill will not excuse the obligation to pay the entire amount for services rendered. Our office will make every effort to assist you in filing and processing your claim.
4. In the event that this office finds it necessary to resort to collection action due to an unpaid bill, the parent/legal guardian or guarantor agrees to pay all costs, expenses, and attorney's fees with collection.
5. Accounts that are delinquent over thirty days will be charged a finance charge of 1.5% per month.
6. Since your child is a minor, it is necessary to obtain your permission before any necessary dental service can be rendered. Authorization is hereby granted. **NO TREATMENT OR ANESTHESIA WILL BE PERFORMED WITHOUT YOUR PRIOR KNOWLEDGE AND CONSENT.**

_____Date_____Relationship to child_____
Signature of parent/legal guardian/guarantor