WELCOME TO OUR ORTHODONTIC OFFICE

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

PATIENT INFORMATION

Patient Name: ____Today's Date ________________________
Last First MI

____ Male ____ Female ___ Mr. ___ Mrs. ___Ms. ___Miss ___Dr. Date of Birth___________________

Home Address: ____
Street City State Zip

Home Phone#_______________Work Phone#_____________Marital Status:____ Married____ Separated ____Divorced ____Widowed ____Single

E-MAIL ADDRESS (Needed to Confirm Appointments)____

HEALTH INFORMATION

Dentist 's Name: ____________________________Address: ______________________________________Phone# _________________

Have you ever had any complications following dental treatment? ____yes ____no

If yes please explain:____

Physician's Name: _________________________Address: ____Phone# _________________

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

If yes please explain: ____

Are you now under the care of a physician? ____yes ____no If yes please explain: ____

Are you now taking any medication? ____yes ____no If yes please explain: ____

Have you ever had any of the following? Please check those that apply:

___AIDS or HIV positive ___Blood/Bleeding disorder ___Heart Disease/Surgery ___Pregnant Now?

___Allergies: **Sulfa Drugs** ___Cancer ___Heart Murmur/Rheum. Fever ___Radiation/Chemotherapy

___Allergies: Codeine ___Diabetes ___Stomach Problems/Ulcer ___Stroke

___Allergies: ________ ___Dizziness/Fainting ___Hepatitis (Liver Disease) ___Tuberculosis

___Anemia ___Ear Disease ___High Blood Pressure ___Tumors/Growth

___Arthritis/Joint Disease ___Epilepsy/Seizures ___Kidney Disease ___Venereal Disease

___Artificial Joints ___**Eye Disease** ___Mental/Nervous Disorder ___Other ______________

___**Asthma**/Resp. Disease ___Glandular/Hormonal Dis. ___Pacemaker

Do you have any health problems that need further clarification? _____yes ____no

If yes please explain: ____

Emergency contact other than your spouse: 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) ____

Have you 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? _________________________________

Do you grind your teeth? ____yes ____no ____Day ____Night

Finger or tongue habits? ______________________________ Age stopped _____________________

What is your attitude toward braces: ____Good ____Bad ____Indifferent

FINANCIAL INFORMATION

Who will pay this account?______________________________________ Relationship to patient ____

YOUR EMPLOYMENT: SPOUSE'S NAME: ____

Occupation ____ Spouse's occupation____

Employer ____ Employer ____

Work address ____ Work address ____

City ________________________________St _________ Zip _______ City _________________________________St _______ Zip ___________

Your Social Security # ______________________________________ Spouse's Social Security # ____

Driver's license # ____ Driver's license # ____

If paying by check: Bank name _________________________________ Branch ___________________________Account # ___________________

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# ____________________________

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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# ____________________________

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AGREEMENT FOR DENTAL SERVICES

1. The patient hereby retains Dr. Arthur L. Kapit to render orthodontic services to and for your benefit.
2. The patient 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 patient 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 patient 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 all the 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 patient 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.

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Signature of patient