BEL AIR ORTHODONTICS

Stephen L. Godwin, DMD, DMSc
Practice Limited to Orthodontics

410-838-2244 **610 S. Main Street**
410-893-793 fax **Bel Air, MD 21014**

Welcome To Our Office

The benefits of a happy, healthy smile are immeasurable! Comfort, function and self esteem are realistic objectives of orthodontic treatment. We hope to exceed your expectations as we pursue that goal. Please fill out these forms completely. The better we communicate, the better we can care for you.

Tell Us About Your Child

Today's Date:_____ ☐Male ☐Female

Child's Name:_____

Nickname:_____ Email _____

Child's Date of Birth:_____/_____/____Child's Age:_____

Child's Home Phone: _____

Child's Address: _____

_____

School:_____

Hobbies/Sports:_____

Does you child play a musical instrument? ☐ Yes ☐ No

If yes, please specify:_____

Who Is Accompanying Your Child Today?

Name:_____ Relationship:_____

Do you have legal custody of this child? ☐ Yes ☐ No

List brothers/sisters and ages:_____

_____

Names of family members seen by us and when they were treated:_____

_____

Your Child's Dental History

Dentist's Name: _____

Dentist's Address:_____

_____

Dentist's Phone:_____Last Visit:_____

Have you had or are you currently under orthodontic treatment? ☐ Yes ☐ No If yes, name and address of previous orthodontist: _____

_____

Phone:_____Last visit:_____

Mother's Information: ☐Stepmother ☐Guardian

Name:_____Birth Date: ____/____/____

Address if different from child:_____

_____

Home Phone:_____Work: _____

Employer:_____

Job Title:_____SS#:_____

Father's Information: ☐ Stepfather ☐ Guardian

Name:_____Birth Date:____/____/____

Address if different from child:_____

_____

Home Phone:_____ Work:_____

Employer:_____

Job Title:_____SS#:_____

Responsible Party Information:

Name: _____

Address if different from above:_____

_____

Home Phone:_____Work:_____

Employer: _____

SS#:_____

How Did You Find Us and Who May We Thank For Referring You To Our Office?
(Please mark <u>all</u> boxes that apply.)

☐ My dentist or ☐ hygienist
☐ A family member was treated or is being treated here.
Please specify whom:_____
☐ My neighbor, friend, co-worker, teacher or family physician recommended you. Please specify: _____
_____
Saw your advertisement in ☐ Verizon or ☐ Yellow Book
☐ Our website ☐ Other website; please specify _____
☐ Google search ☐ Insurance Directory/Website
☐ School Presentation ☐ Church Bulletin
☐ Harford Kids Magazine ☐ Aegis Kids News
☐ Other, please explain: _____

CONTINUED ON BACK

What Are Your Concerns Regarding Your Child's Smile, Bite and/or Teeth?

_____

_____

Is your child in good health? ☐ Yes ☐ No If no, please explain: _____

_____

Child's physician: _____

Physician's Phone:_____Last visit:_____

Please list all drugs your child is allergic to: _____

_____

Is your child allergic to latex ☐ nickel ☐ ?

Please list all drugs your child is currently taking: _____

_____

Has your child had any major changes in his/her health in the past year? ☐ Yes ☐ No
If yes, please specify:

_____

Has your child been hospitalized within the past year? If yes, please specify: ☐ Yes ☐ No

_____

Does your child need to be premedicated with antibiotics before dental treatment? ☐ Yes ☐ No
If yes, please specify:

_____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Does/Did Your Child Have Any Of The Following Habits?

Thumb/finger sucking	Y N	Mouth breathing	Y N
Lip biting/sucking	Y N	Tongue thrust	Y N
Teeth clenching/grinding	Y N	Nail biting	Y N

Has Your Child Ever Had Any Of The Following Medical Problems/Procedures?

Heart problems/murmur	Y N	Heart disease	Y N
Difficulty in breathing	Y N	High blood pressure	Y N
Difficulty in swallowing	Y N	Rheumatic fever	Y N
Difficulty in sleeping	Y N	Hepatitis	Y N
Persistent cough	Y N	Herpes	Y N
Sinus problems	Y N	HIV/AIDS	Y N
Frequent vomiting/nausea	Y N	Syphilis/Gonorrhea	Y N
Recent weight loss	Y N	Thyroid Disease	Y N
Dizziness/Fainting Spells	Y N	Kidney Disease	Y N
Seizures/Epilepsy	Y N	Tumors/Cancer	Y N
Joint Pain	Y N	Radiation Treatment	Y N
Blurred Vision	Y N	Anemia	Y N
Headaches	Y N	Asthma	Y N
Hearing Problems	Y N	History of diabetes	Y N
Emotional Problems	Y N	Skin disorders	Y N
Stomach Problems/Ulcers	Y N	Learning difficulties	Y N
Frequent mouth ulcers	Y N	Speech difficulties	Y N
Allergies	Y N	Chewing difficulties	Y N
Pain in jaw/head/neck	Y N	Neck/jaw/head injury	Y N

Has your child experienced clicking sounds or pain of the jaw joints upon opening/closing of the mouth? ☐ Yes ☐ No

Has your child experienced any other serious medical conditions not list above? ☐ Yes ☐ No If yes, please specify:_____

_____

_____

Has your child experienced her first period? ☐ Yes ☐ No
Is your child pregnant? ☐ Yes ☐ No

Thank you for filling out this form completely. It will enable us to help your child more effectively. If you have any questions at any time, please feel free to ask.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical history. I authorize the doctors and staff at Bel Air Orthodontics to perform the necessary dental services associated with my child's orthodontic care.

_____
Signature of parent or guardian Date

Relationship to patient_____

I understand that I am responsible for payment of services rendered.

_____
Signature of parent or guardian Date

To receive updates on current events, contests and exciting news from Bel Air Orthodontics, please provide us with you or your child's email address. _____ (Your email address will be held in strictest confidence.)

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Dental Insurance Information

Do you have dental insurance? ☐ Yes ☐ No

If you have dental coverage, our staff is happy to assist you in verifying your coverage, filing your claims, and working with you to maximize your insurance reimbursement for covered services. While we are pleased to file dental claims on your behalf, we are not responsible for any limitations in coverage that may be included in your plan.

The following information regarding your coverage is required for filing of claims:

Primary Orthodontic Insurance

Insurance Co. Name:_____

Address:_____

Phone: _____Group #: _____ Policy #: _____

Policy Owner's Name:_____SS#:_____

Relationship to Patient:_____ Policy Holder's DOB:_____/_____/_____

Policy Owner's Address:_____Phone:_____

Employer: _____Employer's Address:_____

Effective Date of Coverage: _____

I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I certify that the information I have provided is true and correct to the best of my knowledge. I understand that it is my responsibility to advise Bel Air Orthodontics of any changes in my insurance coverage or policy information.

_____

Signature/Primary Policy Holder Date

Secondary Orthodontic Insurance

Insurance Co. Name:_____

Address:_____

Phone: _____Group #: _____ Policy #: _____

Policy Owners Name: _____SS#:_____

Relationship to Patient:_____ Policy Holder's DOB:_____/_____/_____

Employer: _____Employer's Address:_____

Effective Date of Coverage: _____

I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I certify that the information I have provided is true and correct to the best of my knowledge. I understand that it is my responsibility to advise Bel Air Orthodontics of any changes in my insurance coverage or policy information.

_____

Signature/Secondary Policy Holder Date

For Office Use Only

Patient Name:_____ Birthdate:_____

Address:_____ Phone:_____

Lifetime Maximum:_____ind. or fam. (circle)__ Payable @ _____% Used to date:_____ Waiting Period? Y/N, If yes:_____

Ded:_____ Paid yet?_____ Age Restrictions:_____ Who: Employee, Spouse, Dependents (circle)

Disbursement:_____% IP, AUTO or RE-SUBMIT (circle), MONTHLY or QRTLY or SEMI-ANNUALLY or ANNUALLY (circle)_____

_____

Records thru Ortho LTM or Preventative: Pan (CDT code D0330):_____ Ceph (CDT code D0340):_____

Photos (CDT code D0350):_____ Models (CDT code D0470):_____

Staff Name & Date:_____Ins. Rep. Name:_____