Speck Orthodontics, PA

5335 Edloe Street, Houston, TX 77005 ● Office (713) 668-6878 ● Fax (713) 668-0702 ● www.speckortho.com

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____ Nickname: _____

Male ☐ Female ☐ Date of Birth: _____/_____/_____ Age of Patient: _____ Marital status: _____

Occupation: _____ Employer Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Contact Information: Preferred Number for us to reach you: **HOME CELL WORK OTHER**

Home #: _____Work #: _____ EXT _____ Cell#: _____

Other: _____ E-mail Address: _____

General Dentist: _____ Date of last dental cleaning: _____

Whom may we thank for your referral? _____

Have any other family members been treated by Dr. Speck? ☐ YES ☐ NO

Name(s) and relation(s) _____

SPOUSE INFORMATION

His/ Her Name: _____

Employer: _____

Work #: _____ Cell#: _____

PAYMENT POLICY

Full payment is due at time of treatment for Initial Exams, Reobservations, X-rays, Models, Diagnostic Photos and the Consultation/ Treatment Evaluation. If your insurance covers these charges or a portion of these charges, we will refund you the amount paid by insurance. We do a complimentary insurance check and inform you of their coverage at your Consultation/Treatment Evaluation.

DENTAL INSURANCE

(ALL selections **must** be complete in order to verify insurance)

Please give your card to a receptionist so we may make a copy.

Policy Holder's Name: _____

Social Security or ID #: _____

Date of Birth: _____

Relationship to Patient: _____

Employer: _____

Insurance Company Name: _____

Insurance Company Phone #: _____

Group #: _____

ORTHODONTIC INSURANCE

Orthodontic insurance generally has a lifetime maximum amount of benefits, and the amount of this maximum will be necessary to offset full cost once active treatment has begun. Our insurance Department will file for your insurance. Insurance carriers generally pay out benefits over the course of treatment and not in one lump sum. If you have any further questions, please feel free to ask to speak to someone in our Billing Department.

MEDICAL HISTORY

Has patient ever had any of the following medical problem(s)?

☐ Abnormal Bleeding
☐ Asthma
☐ Congenital Heart Defect
☐ Diabetes
☐ Hearing Impairment
☐ Hemophilia
☐ HIV
☐ Lupus
☐ Tuberculosis (TB)
☐ ADD/ADHD
☐ Cancer
☐ Epilepsy
☐ Handicap/ Disabilities
☐ Heart Murmur
☐ Hepatitis
☐ Kidney/Liver Problems
☐ Rheumatic Fever

☐**Allergies** (Drugs, Latex, Metals, Plastic) _____

☐Any Operations (please list) _____

_____

Other medical conditions (please explain):

_____

Please list ALL medications being taken at this time:

_____

• Is the patient ADOPTED? ☐YES ☐NO

•Has the patient ever taken Fosamax (for osteoporosis)? ☐ YES ☐NO

•Has the patient ever taken Biophosphonates (Paget's Disease, Hypercalcemia, multiple myeloma and bone cancers)? ☐YES ☐NO

DENTAL HISTORY

Does/did the patient have any of the following habits?

☐ Clenching/ Grinding teeth
☐ Mouth Breather
☐Speech Problems
☐ Lip Sucking
☐ Nail Biting
☐ Thumb/Finger Sucking

Have adenoids or tonsils been removed? ☐YES ☐NO

When? _____

Were there any premature deciduous (baby) tooth losses? ☐ YES ☐NO Age: _____

☐ YES ☐NO Any injuries, trauma or operations to the area about the face? Please specify: _____

☐YES ☐ NO Has the patient ever had any pain or tenderness in their jaw joint (TMJ)? When? _____

☐YES ☐NO Is there a clicking or popping sound in the jaw joint (TMJ)? When does this occur? _____

Are teeth brushed daily? ☐YES ☐NO

Are teeth flossed daily? ☐YES☐NO

Has the patient been evaluated or had ***orthodontic*** treatment before? ☐YES ☐NO

When: _____

By Whom: _____

INITIAL EXAM INFORMATION

The following is a list of charges needed to diagnose the patient and for the Doctor to develop a treatment plan. **At this initial exam, it will be required that you pay these charges IN FULL if Records are taken. Please see "Payment Policy" on the front page.**

Cost for Initial Exam	***No Charge***
Panoramic Film	$70.00
Cephalometric Films	$70.00
Diagnostic Casts/ Models	$65.00
Diagnostic Photographs	$38.00
TOTAL for all DIAGNOSTIC RECORDS	**$243.00**

TREATMENT EVALUATION

After Records have been taken, a "CONSULTATION" appointment will be scheduled, where the Doctor will present the patient a **Treatment Evaluation**. This takes up to two weeks for the Doctor to prepare. Treatment will not begin until a Consultation/ Treatment Evaluation is presented. **There will be a charge of $75.00 due at the time of the Consultation/Treatment Evaluation.**

H.I.P.A.A.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Speck Orthodontics, P.A. is in compliance with the HIPAA. Please take a moment to sign our acknowledgement below.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____ Relation to Patient _____

Signature (Patient Signature if 18 years or older) _____

Date _____

THANK YOU FOR CHOOSING OUR OFFICE!