BELL ORTHODONTIC SOLUTIONS

Thank you for selecting our office for your comprehensive orthodontic needs! It is our goal to provide you with the best possible care. To help us meet all of your needs, please fill out this form completely. Thank you!

Patient Information

Name _____ *Birthdate* _____ *Home Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____

If student, Name of school _____ *Male* ◯ *Female* ◯

Spouse or Parents' Names _____

Marital Status (if patient is a minor, please give parents' status) *Single* ◯ *Married* ◯ *Divorced* ◯ *Widow* ◯

Whom may we thank for referring you? _____

Have we treated any of your family members? _____

Family e-mail address _____

Responsible Party

Name of Person Responsible for this Account _____ *Relationship* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Social Security # _____ *Home Phone* _____ *Cell Phone* _____ *E-mail* _____

Name of Person Responsible for this Account _____ *Relationship* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Social Security # _____ *Home Phone* _____ *Cell Phone* _____ *E-mail* _____

Dental Insurance Information

Name of Card Holder _____ *Relationship* _____

Birthdate _____ *Social Security #* _____ *Ins Effective Date* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID#* _____

Ins Co Address _____ *City* _____ *State* _____ *Zip* _____

Ins Co Phone _____ *Lifetime Maximum* _____ *Percent* _____

If you have additional dental insurance, please complete the following:

Name of Card Holder _____ *Relationship* _____

Birthdate _____ *Social Security #* _____ *Ins Effective Date* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID#* _____

Ins Co Address _____ *City* _____ *State* _____ *Zip* _____

Ins Co Phone _____ *Lifetime Maximum* _____ *Percent* _____

Please list the names of any brothers or sisters (or children)

Name _____ *Age* _____ *Name* _____ *Age* _____

Name _____ *Age* _____ *Name* _____ *Age* _____

Patient Medical History

Physician _____ *Office Phone* _____

	Yes	No
1. Are you under any medical treatment now?	◯	◯
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ _____	◯	◯
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	◯	◯
4. Have you ever taken Phen-Fen/Redux?	◯	◯
5. Do you use tobacco?	◯	◯
6. Do you use controlled substances?	◯	◯
7. Are you wearing contact lenses?	◯	◯

8. Are you allergic to or have any reactions to the following?	Yes	No
Local Anesthetics (ex. Novacaine)	◯	◯
Penicillin or other antibiotics	◯	◯
Sulfa Drugs	◯	◯
Barbiturates	◯	◯
Sedatives	◯	◯
Iodine	◯	◯
Aspirin	◯	◯
Any metals (ex. nickel, mercury, etc.)	◯	◯
Latex Rubber	◯	◯
Other (please list) _____		

9. Women Only	Yes	No
a) Are you pregnant or think you may be pregnant?	◯	◯
b) Are you nursing?	◯	◯
c) Are you taking oral contraceptives?	◯	◯

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	◯	◯	Heart Disease	◯	◯	Chest Pains	◯	◯
Heart Attack	◯	◯	Cardiac Pacemaker	◯	◯	Easily Winded	◯	◯
Rheumatic Fever	◯	◯	Heart Murmur	◯	◯	Stroke	◯	◯
Swollen Ankles	◯	◯	Angina	◯	◯	Hay Fever/Allergies	◯	◯
Fainting/Seizures	◯	◯	Frequently Tired	◯	◯	Tuberculosis	◯	◯
Asthma	◯	◯	Anemia	◯	◯	Radiation Therapy	◯	◯
Low Blood Pressure	◯	◯	Emphysema	◯	◯	Glaucoma	◯	◯
Epilepsy/Convulsions	◯	◯	Cancer	◯	◯	Recent Weight Loss	◯	◯
Leukemia	◯	◯	Arthritis	◯	◯	Liver Disease	◯	◯
Diabetes	◯	◯	Joint Replacement	◯	◯	Heart Trouble	◯	◯
Kidney Disease	◯	◯	Hepatitis/Jaundice	◯	◯	Respiratory Problems	◯	◯
AIDS or HIV Infection	◯	◯	Sexually Transmitted Disease	◯	◯	Mitral Valve Prolapse	◯	◯
Thyroid Problem	◯	◯	Stomach Troubles/Ulcers	◯	◯	Other _____	◯	◯

Patient Dental History

Dentist Name _____ *Address* _____ *Phone* _____

How long has it been since your last visit to the dentist? _____

	Yes	*No*
Do you make regular dental visits?	⬭	⬭
Do you clench or grind your teeth?	⬭	⬭
Does your jaw click or pop?	⬭	⬭
Have you experienced any pain or soreness in the muscles of your face or around your ears?	⬭	⬭
If yes, please explain _____		
Are any of your teeth loose?	⬭	⬭
Have you ever had any periodontal (gum) treatment or surgery?	⬭	⬭
If yes, please explain _____		
Have you ever had any permanent or "extra" (supernumerary) teeth removed?	⬭	⬭
Are any of your teeth sensitive to hot or cold?	⬭	⬭
Do you have a mouth breathing habit, snoring or difficulty breathing?	⬭	⬭

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. If there are any changes later to this history record or medical/dental status I will so inform the practice.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient or responsible party *date*

_____ _____
Signature of dental staff member *date*

Medical/Dental History Reviewed and Updated:

_____ _____ _____
Signature of patient or responsible party *Signature of dental staff member* *date*

Bell Orthodontic Solutions, LLC

Wisconsin Consent

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, health care operations and (b) our disclosure of the individuals dental care records to carry out treatment, payment activities and health care operations.

Section A: Individual Giving Consent

Name: _____

Patient Name: _____

Address: _____

Phone: _____

To the Individual: Please read the following and complete the information requested

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practice Notice: You have the right to read our privacy practices notices before you decide whether or not to sign this consent. Our notice provides a description of our treatment, payment activities, health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

Section B: The Uses and Disclosures Being Authorized

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practice Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including your insurance companies, dentist(s), doctors(s), and immediate family members. This will also allow us to inform a patient's escort of their progress. **If there is anyone else you would like to include or exclude from this grouping please list below.**

_____ _____

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up medical supplies, x-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

Section C: Revocation

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the contact office written below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Bell Orthodontic Solutions, W68 N930 Washington Ave., Cedarburg, WI 53012 (262) 377-7410

Patient or Guardian's Signature

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

_____ _____

Patient or Guardian's Signature Date