

SPECIALIST ORTHODONTICS FOR CHILDREN & ADULTS

Dr. Seth Newman
Dr. Steve Giannoutsos



Patient Name: _____ Chart # _____ Birth Date: _____ Age : _____

Child Male Female Married Single Other _____

Social Security No.: _____ - _____ - _____ E-Mail Address: _____

Home Phone No.: (____) _____ - _____ Work Phone: (____) _____ - _____ Ext. _____ Cell: (____) _____ - _____

Address: _____

Street Apt. City State Zip Code

Name of Parent/Legal Guardian: _____

Who referred you to us: _____

General Dentist Name & Phone#: _____

Doctors Notes

Are you in good health? _____

Have you been hospitalized or had a serious illness in the last five years?

If yes, please explain: _____

Date of last medical exam: ___/___/___ Date of last dental exam: ___/___/___

Have you had problems with previous dental treatment? _____

Chief Complaint: _____

Please check the appropriate answers (leave blank if you do not understand the question).

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--------|--|---|---|---|--|---|--|--|--|--|---|---|--|---|--|---|---|---|--|--|--|--------|--------|---|--|---|--|---|---|---|--|--|
| <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">YES NO</td> <td style="width: 50%; text-align: center;">YES NO</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Chest Pain</td> <td><input type="checkbox"/> <input type="checkbox"/> Dizziness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Shortness of Breath</td> <td><input type="checkbox"/> <input type="checkbox"/> Headaches</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Persistent Cough</td> <td><input type="checkbox"/> <input type="checkbox"/> Fainting Spells</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</td> <td><input type="checkbox"/> <input type="checkbox"/> Blurred Vision</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Seizures, Epilepsy</td> <td><input type="checkbox"/> <input type="checkbox"/> Frequent Urination</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Dry Mouth</td> <td><input type="checkbox"/> <input type="checkbox"/> Joint Pain, Stiffness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Frequent Vomit, Nausea</td> <td><input type="checkbox"/> <input type="checkbox"/> Heart Disease</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Jaundice</td> <td><input type="checkbox"/> <input type="checkbox"/> AIDS, HIV Infection</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Thyroid</td> <td><input type="checkbox"/> <input type="checkbox"/> STD</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Do you have any other diseases</td> <td></td> </tr> </table> | YES NO | YES NO | <input type="checkbox"/> <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> <input type="checkbox"/> Seizures, Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> <input type="checkbox"/> Joint Pain, Stiffness | <input type="checkbox"/> <input type="checkbox"/> Frequent Vomit, Nausea | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Jaundice | <input type="checkbox"/> <input type="checkbox"/> AIDS, HIV Infection | <input type="checkbox"/> <input type="checkbox"/> Thyroid | <input type="checkbox"/> <input type="checkbox"/> STD | <input type="checkbox"/> <input type="checkbox"/> Do you have any other diseases | | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">YES NO</td> <td style="width: 50%; text-align: center;">YES NO</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Heart Attack, Heart Defects</td> <td><input type="checkbox"/> <input type="checkbox"/> Tumors, Cancer</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</td> <td><input type="checkbox"/> <input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> TB, Emphysema</td> <td><input type="checkbox"/> <input type="checkbox"/> Diarrhea, Constipation, Blood in Stools</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Heart Murmurs/Mitral Valve Prolapse</td> <td><input type="checkbox"/> <input type="checkbox"/> Diabetes</td> </tr> </table> | YES NO | YES NO | <input type="checkbox"/> <input type="checkbox"/> Heart Attack, Heart Defects | <input type="checkbox"/> <input type="checkbox"/> Tumors, Cancer | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> TB, Emphysema | <input type="checkbox"/> <input type="checkbox"/> Diarrhea, Constipation, Blood in Stools | <input type="checkbox"/> <input type="checkbox"/> Heart Murmurs/Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <p style="text-align: center;">or medical problems not listed?</p> |
| YES NO | YES NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <input type="checkbox"/> Dizziness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> <input type="checkbox"/> Headaches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> <input type="checkbox"/> Blurred Vision | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Seizures, Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Frequent Urination | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> <input type="checkbox"/> Joint Pain, Stiffness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Frequent Vomit, Nausea | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> <input type="checkbox"/> Thyroid | <input type="checkbox"/> <input type="checkbox"/> STD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Do you have any other diseases | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| YES NO | YES NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack, Heart Defects | <input type="checkbox"/> <input type="checkbox"/> Tumors, Cancer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> <input type="checkbox"/> TB, Emphysema | <input type="checkbox"/> <input type="checkbox"/> Diarrhea, Constipation, Blood in Stools | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmurs/Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Please check the appropriate answers (leave blank if you do not understand the question).

- | | | |
|---|--|--|
| YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> Pre-medicated prior to dental visit | <input type="checkbox"/> <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> <input type="checkbox"/> Are you Pregnant or Nursing |
| <input type="checkbox"/> <input type="checkbox"/> Happy with the appearance of teeth | <input type="checkbox"/> <input type="checkbox"/> Pain/Clicking in Jaw | <input type="checkbox"/> <input type="checkbox"/> Are you taking birth control |
| <input type="checkbox"/> <input type="checkbox"/> Tooth Grinding/Jaw Clenching | <input type="checkbox"/> <input type="checkbox"/> Thumb Sucking | |
| <input type="checkbox"/> <input type="checkbox"/> History of Speech Problems | <input type="checkbox"/> <input type="checkbox"/> Tobacco, in any form | |
| <input type="checkbox"/> <input type="checkbox"/> Periodontal/Gum Problems | <input type="checkbox"/> <input type="checkbox"/> Alcohol | |

Please check allergies: _____ Please list all medications and supplements you are using: _____

- Latex
- Metal
- Penicillin
- Food
- Medications

Please list metal, food or medications you are allergic to: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dental provider of any changes in my health and medication. I consent to an examination (to include x-rays).

Signature and date _____

Jackson Heights Orthodontics

Se habla español

Dental Insurance Information (If you DO NOT have dental insurance, skip to Medical Insurance Information)

The following information is on the insured person:

Name: _____ Relation to Patient: _____
Social Security# _____ - _____ - _____ Birth Date _____ / _____ / _____
Phone Home # (_____) _____ - _____ Work# (_____) _____ - _____ Cell# (_____) _____ - _____
Address _____
Street apt State zip

Primary Dental Insurance Information

My Primary Dental Insurance Company is: _____
Employer information of Insured
Employer Name: _____ Occupation: _____
Address _____
Street City State zip

Secondary Dental Insurance Information

Name of insured: _____
Last First MI
Patient's relationship to insured: () Self () Spouse () Child Other _____
Insured's Birth Date: _____ ID#: _____
Insured's Employer Name: _____ Group #: _____
Insurance Company Name and Address: _____

Medical Insurance Information

I have medical insurance coverage I do not have medical insurance coverage
Name of Medical Insurance Coverage: _____
Medical Insurance Company: _____
Name of insured: _____ Group #: _____
Insured's ID Number: _____
Employer who the Medical Insurance is through: _____

Financial Responsibility

Payment is expected in full at time of service

Please note: we bill insurance companies as a courtesy to the patient-you are ultimately are responsible for all fees incurred in our office!

I understand that by signing below I am allowing Jackson Heights Orthodontics PLLC to use the supplied information to bill insurance coverage for any services rendered that my insurance company may send that benefit to Jackson Heights Orthodontics PLLC (Assignment of Insurance Benefits). I also understand that any co-payments, percentages or fee schedule payments are due from me at time of service.

I am ultimately responsible for any and all balances on my account incurred in any way. I am responsible for any non-covered services, and any balances remaining after my insurance company has paid their portion.

It is my responsibility to keep my coverage active, to be familiar with my plans benefits and to know that I am covered at the time that services are rendered. Any claims denied or unpaid due to my coverage not being in force at time of services, or any other reason will be billed directly to me. It is also my responsibility to ask for a quote on any dental services before they are rendered.

Signature of patient (or legal guardian if minor) Date

Patient Confidentiality Policy

As our patient we want you to know that we respect the privacy of your personal information. The information you supply to us is used to carry out treatment, payment and any healthcare related operations. Use of your personal information for other purposes would require your authorization. We strive to always take reasonable precautions to protect your privacy as outlined under the HIPPA (Health Insurance Privacy and Portability Act) guidelines. We also have the right to change or amend our privacy practices. We support your right to access to your personal dental records. Our office charges a fee for record copies. You have the right to review our privacy notice, and to revoke consent in writing at any time after reviewing our privacy policies. If you have questions about our privacy policies please ask to speak to our HIPPA compliance officer on staff. Our complete privacy policies are available for reading if desired.

Print name of patient: _____

Signature of patient (or legal guardian if minor) Date

Consent for services

- As a condition of our treatment, financial arrangements must be made in advance. All emergency dental services, or any dental services performed, must be paid at the time services are performed.
- We will help prepare the patient insurance forms. However, we cannot render services on the assumption that our charges will be paid in full by any insurance company.
- I understand that treatment plans are estimates only and subject to change depending on unforeseen circumstances that may arise during the course of treatment.
- I understand that the fees estimated for dental services can only be extended for a period of six months from the date of the patient exam.
- I understand as a courtesy I should give at least 24 hours notice for all appointment changes.
- I grant my permission to telephone me at home or at my work to discuss matters related to this form.
- I have read the above conditions of treatment and payment and agree to their consent.

Signature of patient, parent or guardian Date Relationship to Patient

Signature of guarantor of payment/responsible party Date Relationship to Patient

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- Statement of Actual Services Request for Predetermination/Preauthorization
 EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender

M F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person Named in #5

Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender

M F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above

Self Spouse Dependent Child Other

19. Student Status

FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender

M F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH INFORMATION

Permanent

Primary

34. (Place an 'X' on each missing tooth)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number () - 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment
 Provider's Office Hospital ECF Other

39. Number of Enclosures (00 to 99)
Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?
 No (Skip 41-42) Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining
 No Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
 Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI 55. License Number
56. Address, City, State, Zip Code 56A. Provider Specialty Code

57. Phone Number () - 58. Additional Provider ID