SPECIALIST ORTHODONTICS FOR CHILDREN & ADULTS

Dr. Seth Newman
Dr. Steve Giannoutsos

JACKSON HEIGHTS ORTHODONTICS

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).

YES	NO		YES	NO		YES	NO	
☐	☐	Chest Pain	☐	☐	Dizziness	☐	☐	Heart Attack, Heart Defects
☐	☐	Shortness of Breath	☐	☐	Headaches	☐	☐	Tumors, Cancer
☐	☐	Persistent Cough	☐	☐	Fainting Spells	☐	☐	Rheumatic Fever
☐	☐	Sinus Problems	☐	☐	Blurred Vision	☐	☐	Stroke
☐	☐	Seizures, Epilepsy	☐	☐	Frequent Urination	☐	☐	TB, Emphysema
☐	☐	Dry Mouth	☐	☐	Joint Pain, Stiffness	☐	☐	Diarrhea, Constipation, Blood in Stools
☐	☐	Frequent Vomit, Nausea	☐	☐	Heart Disease	☐	☐	Heart Murmurs/Mitral Valve Prolapse
☐	☐	Jaundice	☐	☐	AIDS, HIV Infection	☐	☐	Diabetes
☐	☐	Thyroid	☐	☐	STD			

☐ ☐ Do you have any other diseases or medical problems not listed?

_____

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

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

Please check allergies:
- ☐ Latex
- ☐ Metal
- ☐ Penicillin
- ☐ Food
- ☐ Medications

Please list all medications and supplements you are using: _____

_____

Please ist 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

74-09 37th Ave. Suite 301
Jackson Heights, NY 11372
718-335-4444
www.jhbraces.com

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

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

Permanent																Primary										32. Other Fee(s)	
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	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

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

43. Replacement of Prosthesis? ☐ 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

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	

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