Welcome to Zhu Orthodontics

To get started, we need some information from you. Let us know if you have any questions!

Full Name First Middle (optional) Last

Birth Date Month Day Year **Age** **SSN** (For adults only) **Male** or **Female** ?

Address Street

Secondary Address City State Zip Code

E-Mail **Phone**

Emergency Contact Information

This is my: **Parent** **Guardian** **Spouse** **Other: _____**

Full Name **Birth Date** Month Day Year

Phone **E-Mail**

This is my: **Parent** **Guardian** **Spouse** **Other: _____**

Full Name **Birth Date** Month Day Year

Phone **E-Mail**

Dental Insurance Information

Insurance Co. **Policy #**

Name of Policy Holder / Subscriber

Birth Date **Group #**

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Patient ID:

Referring Party:

Updated Information:

Medical History

Are you taking any medication? List all below.

Are you *allergic* to any medication? List all below.

Have you ever had or currently have any of the following? Please circle all that apply.

Abnormal Bleeding	Diabetes	High Blood Pressure	Radiation/Chemotherapy
Anemia	Epilepsy	HIV or Aids	Rheumatic Fever
Arthritis	Heart Problems	Kidney Problems	Tuberculosis
Asthma or Hay fever	Heart Murmur	Nervous Disorder	Tumor or Cancer
Bone Disorder	Hepatitis Type ___	Pneumonia	Surgeries (Specify Below)
Congenital Heart Defect	Herpes	Prolonged Bleeding	Other (Specify Below)

Are you allergic to or had a bad reaction to any of the following?

Penicillin Latex Metal (Specify Below) Aspirin Sulfur Other (Specify Below)

If you would like to elaborate on any medical conditions you have, please explain:

Have you had your tonsils or adenoids removed?

Tonsils Adenoids

Female Patients: Circle all that apply

I am taking Birth Control I am pregnant

I have problems with my menstrual cycle

Dental History

General Dentist

Dentist Office Name / Location

Phone **Date of Last Cleaning**

Have you ever experienced any of the following?

Clenching or grinding teeth Tongue Thrusting Thumb Sucking

Jaw Pain or Tenderness Nail biting

Do you have any specific dental concerns?

I verify that all the provided information is true and accurate. I authorize the dental staff to perform the necessary dental services. I understand that I am financially responsible for all charges whether or not paid by insurance.

The undersigned has read the above statement and agrees to its content.

Patient or Parent/Guardian Signature **Name (Print)** **Date**

Permission for Diagnostic Records for Orthodontic Treatment

Prior to the start of orthodontic treatment, diagnostic records are taken for review and/or the submission to insurance if applicable for a treatment pre-approval. These records may include but are not limited to: Panoramic X-Ray, Cephalometric X-Ray, Study Models or Impressions, Facial Photographs, and Intra-Oral Photographs. Some of these records may be repeated throughout the treatment for review. If you require copies of these records for a second opinion, transfer, or personal record, there may be an additional fee.

I, undersigned, give Zhu orthodontics my consent to take orthodontic records on myself/my child today and throughout orthodontic treatment when deemed necessary by Dr. Xinsheng Zhu, DDS, PC.

Patient or Parent/Guardian Signature	**Name (Print)**	**Date**

Office Policy Regarding Orthodontic Insurance

Orthodontic insurance coverage is different from general dental insurance. Orthodontic insurance has a one-time lifetime maximum. This is separate from the annual maximum used for general dental visits. The amount of your orthodontic coverage is determined by you (your employer) and your insurance company. Our office does not negotiate the terms of your coverage.

Normally insurance companies only cover a percentage of your orthodontic fee up to a certain amount. The balance of your fee (co-pay) is your responsibility. We will do our best to make payment arrangements that fit your budget. Some insurance companies will only pay you. In this case we are happy to work with you in filing the forms and explaining the terms of your coverage, so you receive the maximum benefits from your policy.

It is your responsibility to provide our office with all insurance information and completed insurance forms. If you have any changes to your insurance policy *you are responsible for notifying us as soon as possible of these changes*.

It is a courtesy to our patients that we accept payment directly from your insurance company, but the financial responsibility remains with the patient or parent. If for any reason your insurance company does not make payment as anticipated, you are responsible for completing your fee to us. It is our office policy, as it is in most orthodontic offices, that braces are not removed until payment is received in full. If at any time you have any questions or concerns regarding your insurance or payments, please call the office and we will be happy to assist you.

I, undersigned, have read and understand the above information

Patient or Parent/Guardian Signature	**Date**

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Notice of Privacy Practices

This office routinely comes into contact with Private Health Information (PHI). To protect your PHI in accordance with the Health Insurance Portability and Accountability Act (HIPAA), this office has put in place measures to protect electronic patient information and ensure confidentiality.

We will *not* share your private health information with third parties without your consent unless deemed medically necessary.

You, the patient, have the right to:

- Request a change in our records
- Ask us not to disclose your information
- Ask us to communicate confidentially

You may refuse to sign this acknowledgement.

I, _____, have read and understand the notice of Zhu Orthodontics' privacy practices

_____	_____	_____
Patient or Parent/Guardian Signature	**Name (Print)**	**Date**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement count could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency prevented us from obtaining acknowledgement
- ○ Other (Specify below)