This initial consultation appointment is to determine whether or not orthodontic treatment is needed, at what age level would be most advantageous, and to give you some insight into orthodontic treatment. If treatment is required, this appointment may also be for the purpose of taking records consisting of x-rays, photographs, and study models. A second appointment will be necessary to confer with the parents of the child, or with the adult patient. At this conference appointment, all aspects of the treatment are thoroughly discussed. If treatment is not indicated at this time, periodic observation appointments may be necessary to assess the proper timing for treatment.

PATIENT INFORMATION:

Date_____Sex M ☐ F ☐ Preferred Number _____
Patient's Full Name_____Preferred Name/Nickname _____
Age_____Date of Birth_____Sports/Hobbies _____
Home Address_____City: _____State_____Zip _____
Relatives or Friends in Treatment _____
Family Dentist_____Referred By_____
Family Physician: _____ Phone: _____Health Status: _____
Allergies: _____
Medications or Drugs Being Taken: _____
In Case of Emergency, Name and Phone Number of Nearest Relative/Friend: _____
_____
Additional Comments: _____
_____
Need for Antibiotic Prophylaxis for Heart Condition ☐ Yes ☐ No
Father's Name_____Mother's Name _____
Father's Business Phone_____Occupation_____S.S. #_____
Place of Employment _____
Mother's Business Phone_____Occupation_____S.S.#_____
Place of Employment _____

RESPONSIBLE PARTY INFORMATION

Name_____Date of Birth_____
Relationship to Patient_____S.S. # _____
Home Address_____Home Phone _____
Email address: _____
Place of Employment_____Business Phone _____
Is Patient Covered By Orthodontic Insurance? _____
Name of Insurance Company _____

PLEASE READ: In the event that an orthodontic problem exists, you will be counseled to have orthodontic records taken. These records usually consist of study models, tooth and facial x-rays, photographs, and diagnostic measurements and tracings. The doctors use this information to diagnose the extent of the problem and to formulate a treatment plan. Our fee for treatment includes these records. **However, should you elect not to pursue treatment; you will be responsible for the cost of these records, as well as any collection fees incurred.** Your signature below indicates that you are aware of this office policy.

_____ _____

Signature (Parent's signature if minor) **Please Print Name**

Dental Insurance Carrier Information

***We strongly suggest that you contact your insurance company to familiarize yourself with your benefits prior to your first orthodontic appointment

Primary Insurance Carrier Name_____Phone_____
Insurance Carrier Address _____
Employer Name and Phone_____
Name of Insured Party_____SS#_____Birth Date_____

Secondary Insurance Carrier Name_____Phone_____
Insurance Carrier Address_____
Employer Name and Phone_____
Name of Insured Party_____SS#_____Birth Date_____

Dental History

Date of most recent dental examination_____
Reason for this Orthodontic Appointment_____

Please circle Yes or No. Questions pertain to the patient being examined.

Yes No Does the patient follow directions?
Yes No Does the patient have learning disabilities or need extra help with instructions?
Yes No Is patient sensitive, self-conscious?
Yes No Any problems with previous dental treatment?_____
Yes No Ever been treated for "TMJ" problems (jaw joint and facial muscle pain)?
Yes No Previous orthodontic consultation or treatment?
Yes No Periodontal surgery or treatment?
Yes No Clicking or soreness when mouth is opened?
Yes No Oral surgery?
Yes No Teeth extracted or missing?
Yes No Problems with bleeding or gum healing after surgery?
Yes No Injuries to the face, mouth or teeth?
Yes No Grinding/clenching teeth?
Yes No Sensitivity to heat, cold or sweets?
Yes No Fluoride treatments?
Yes No Speech therapy?
Yes No Mouth breathing habit, snoring, difficulty in breathing?
Yes No Difficulty in chewing or jaw opening?
Yes No Jaw fractures, cysts, mouth infections?
Yes No Frequent canker sores or cold sores?
Yes No Thumb or finger sucking habit? Until_____

Other _____

Medical History

For the following questions circle Yes or No. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Yes No Birth defects or hereditary problems?
Yes No Bone fractures, any major accidents?
Yes No Is patient pregnant?
Yes No Rheumatoid or arthritic conditions?
Yes No Endocrine or thyroid problems?
Yes No Kidney problems?
Yes No Diabetes?
Yes No Cancer or been treated for a tumor?
Yes No Stomach ulcer or hyperacidity?
Yes No Polio, mono, tuberculosis, pneumonia?
Yes No Problems with immune system?
Yes No AIDS or HIV positive?
Yes No Hepatitis, jaundice or liver problems?
Yes No Fainting spells, seizures, epilepsy or neurologic problems?
Yes No Mental health or behavioral problems?
Yes No Vision, hearing, tasting or speech difficulties?
Yes No Loss of weight recently, poor appetite?
Yes No Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
Yes No High or low blood pressure?
Yes No Tire easily?
Yes No Chest pain, shortness of breath or swelling ankles?
Yes No Cardiovascular problem (heart trouble, heart attack, angina?)
Yes No Skin disorder?
Yes No Frequent headaches, colds or sore throats?
Yes No Eye, ear, nose, throat, sinus condition?
Yes No Hayfever, hives?
Yes No Asthma?
Yes No Tonsil or adenoid conditions?
Yes No Allergies or drug reactions?
Yes No Are you taking medications or non-prescription medicine?

Yes No Does the patient currently have or ever had a substance abuse problem?
Yes No Operations, surgeries?
Yes No Hospitalized for
Yes No Other physical problems or symptoms?
Yes No Being treated by another health care professional for

Please describe any other disease, condition, medical problems or other information that we should be aware of:

I have read and understand the above questions, and I certify that the above information I have given is true and complete to the best of my knowledge. I will not hold this orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of parent, guardian or adult patient **Date**

INFORMED CONSENT PERTINENT TO PATIENTS UNDERGOING ORTHODONTIC TREATMENT

As a rule, excellent orthodontic results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering or undergoing orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These are seldom enough to contraindicate treatment, but should be considered in making the decision to wear orthodontic appliances.

Throughout life tooth position is constantly changing. This is true with all individuals regardless of whether they have had orthodontic treatment or not. Post-orthodontic patients are subject to the same subtle changes that occur in non-orthodontic patients. In the late teens or early twenties our patients may notice slight irregularities developing in their front teeth. This is particularly true if their teeth were extremely crowded prior to treatment. Retainer wear is critical to minimize tooth shifting.

Decalcification (permanent markings), decay, or gum disease can occur if patients do not brush their teeth properly and thoroughly during the treatment period. Excellent oral hygiene and plaque removal is a must. Sugars and between meal snacks should be eliminated. Routine recall appointments with you general dentist must be kept.

On rare occasions the nerve of a tooth may become non-vital. A tooth that has been traumatized from a deep filling or even a minor blow can die over a long period of time with our without orthodontic treatment. An undetected non-vital tooth may flare up during orthodontic movement requiring endodontic (root canal) treatment to maintain it.

In some cases, the root ends of the teeth are shortened during treatment. This is called root resorption. Under healthy circumstances the shortened roots are no disadvantage. However, in the event of gum disease later in life, root resorption could reduce the longevity of affected teeth. It should be noted that not all root resorption arises from orthodontic treatment. Trauma, cuts, impaction, endocrine disorders, and idiopathic reasons can also cause root resorption.

There is also a risk that problems may occur in the tempromandibular joints (TMJ). Although this is rare, it is a possibility. Tooth alignment or bite correction can improve tooth related causes of TMJ pain but not in all cases. Tension appears to play a role in the frequency and severity of joint pains.

Occasionally a person who has grown normally and in average proportion may not continue to do so. If growth becomes disproportionate, the jaw relation can be affected and original treatment objectives may have to be compromised. Skeletal growth disharmony is a biological process beyond the orthodontist's control.

Perfection is our goal. However, in dealing with human beings and problems of growth and development, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted.

The total time for treatment can be delayed beyond our estimate. Lack of facial growth, poor elastic wear or headgear cooperation, broken appliances and missed appointments are all important factors which could lengthen treatment time and affect the quality of the result.

Headgear instructions must be followed carefully. A headgear that is pulled outward while the elastic force is attached can snap back and poke into the face or eyes. Be sure to release the elastic force before removing the headgear from the teeth.

I have read and understand this letter of information.

Signature_____**Date**_____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOUR PRIVACY IS IMPORTANT TO US.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax, email address, home address, social security numbers, and demographics data) may be used or disclosed by us in one or more of the following aspects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery,etc);
- To third party payers (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental board, etc.) in connection with obtaining certification, licensure or accreditation, Internally, to all staff members who have any role in treatment
- Educational purposes
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling etc.;
- To your family and close friends involved in your treatment, and/or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health- related benefits and services that may be of interest to you.

And other uses or disclosures of your protected health information will be made only after obtaining written authorization, which you have the right to revoke.

X_____

Signature (Parent's signature if minor)

PREMIER DENTAL CARE
DR. MICHAEL SOBOL
2730 HANOVER PIKE
MANCHESTER, MD 21102
410-374-4882

Financial Policy

Thank you for choosing our practice for your dental care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment. Just as we are committed to providing you with the very best dentistry has to offer, we are also committed to making dentistry financially comfortable for you as well. Please take the time to read the following, initial each section, and sign & date the bottom of this form.

_____ We will review the estimated cost of treatment as well as review your payment options before treatment begins. We accept Cash, Checks, Visa, MasterCard, and Discover. We also work with CareCredit and Lending Club for patients that need to make monthly payments. **Please note that the processing fees associated with CareCredit and Lending Club are non-refundable.*

_____ As a courtesy, we will accept assignment of your insurance benefits and file your primary insurance claims. However, we do require payment in full of your co-pay and deductible at the time you receive treatment. It is important to understand that your insurance benefits are negotiated between your employer and your insurance company.

_____ As a result some, or perhaps all of the treatment provided may not be covered by your insurance. The cost of these procedures will be your responsibility. Please be aware that some insurance carriers will not allow you to assign your benefits to our office. In those cases, payment is due in full at the time of the visit and your insurance company will reimburse you directly.

_____ Due to the extensive amount of time our staff and doctors devote to preparing and reserving time for your treatment, reservations of 1 hour or longer will require a deposit of half of the treatment fee to make your reservation, which will include a $50.00 non-fundable deposit should the appointment be missed or cancelled with less than 48-hour's notice.

_____ Full payment is due at the time your receive treatment unless arrangements have been made ***prior*** to the start of any procedure.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failing to confirm your appointment may result in the loss of your reservation and a possible charge for the time reserved.

_____ Appointments that are missed and/or cancelled with less than 48-hour's notice may require a future reservation fee prior to being rescheduled

_____ There will be a fee of $35.00 for any checks returned a Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

- Interest charge of 1.5% per month
- 18% APR collections fees (up to 25% of the full balance)
- Legal fees or Collection Services

I authorize payment to be made directly to Premier Dental Care by my insurance company. I accept full financial responsibility for all services performed in this office. I acknowledge that I have received and reviewed the Office Policies.

_____ _____

Patient Signature Date

Premier Dental Care

Michael Sobol, DDS
2740 Hanover Pike
Manchester, MD 21102
410.374.4882

Acknowledgement of Receipt

Notice of Privacy Practices
Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. We would, however, like your acknowledgement that you have been notified that the notice is available for your review. You may request a paper copy of the notice by asking any of our
team members.

Patient Name: _____

Signature:_____

Date:_____

An attempt was made to obtain written acknowledgement of receipt of our privacy practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented obtaining acknowledgement
- ☐ Other (please specify)_____
  _____
  _____

Team Member's Name: _____

PREMIER DENTAL CARE
DR. MICHAEL SOBOL
2730 HANOVER PIKE
MANCHESTER, MD 21102
410-374-4882

Website and Social Media Release

Patient's Name (Please Print): _____

Premier Dental Care, on occasion, take photos and/or videos of patients to be used in our office, for our website (www.PremierDentalCare.net), Facebook, Twitter, Instagram, newsprint and/or related publications. This list is not inclusive, but serves to demonstrate situation is which patients may be photo'd or filmed.

Please Check One Below:

_____I give permission to Premier Dental Care to display my photo(s) or video(s) in association with Premier Dental Care events, functions and/or publications

_____I do NOT give permission to Premier Dental Care to display and/or post my photo(s) or video(s) in association with Premier Dental Care events.

_____ _____
Signature of Patient: Date

_____ _____
If patient is under 18 years of age – Signature of Patient's Parent/Legal Guardian Date