UC smiles
ORTHODONTICS

Date: _____

NEW PATIENT INFORMATION

Patient's name _____
First Last

Address _____
Street City Zip

Home Phone # _____ Cell Phone # _____

Birthdate _____ Social Security # _____

Email _____

RESPONSIBLE PARTY INFORMATION

Primary

Name _____
First Last

Address _____
Street City Zip

Home/Cell Phone # _____ Relationship to Patient _____

Secondary

Name _____
First Last

Address _____
Street City Zip

Home/Cell Phone # _____ Relationship to Patient _____

MEDICAL HISTORY

Physician Name:_____

Date of Last Visit_____ Phone #_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?_____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness?_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia Anemia

Dizziness Herpes Prolonged Bleeding Arthritis Epilepsy High Blood Pressure

Radiation/Chemotherapy Asthma or Hayfever Gastrointestinal Disorders HIV / Aids

Rheumatic Fever Bone Disorders Heart Problems Kidney problems Tuberculosis

Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware

of? _____

EMERGENCY CONTACT INFORMATION

Name:_____

First Last

Home/Cell Phone # _____ Relationship to Patient_____

DENTAL HISTORY

General Dentist:_____

Office Phone #:_____ Date of last visit:_____

What concerns you most about your teeth?

_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you presently in any dental pain? Where?_____

Yes No Have you ever lost or chipped any teeth?_____

Yes No Have there been any injuries to face, mouth, or teeth?_____

Yes No Is any part of your mouth sensitive? Where?_____

Yes No Do your gums bleed when you brush?

Yes No Do you have any type of thumb or tongue habit?

Yes No Are you a mouth breather?

Yes No Are you aware of your jaw clicking or popping?

Yes No Are you aware of clenching/grinding of your teeth?

Female Patients only:

Yes No Are you pregnant? _____

Yes No Has menstruation started?_____

ORTHODONTIC BENEFIT

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understood this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr.Adebimpe "Bebe" Ibitayo to perform a complete orthodontic evaluation.

Signature

Date

DENTAL INSURANCE INFORMATION - ORTHODONTIC COVERAGE ONLY

Primary Insurance

Name of Insurance:_____ Phone #_____

Name of Policy Holder _____

First Last

Policy Holders DOB: _____ Policy Holder SSN:_____

Group #:_____ Policy #:_____

Policyholder Employer:_____

I UNDERSTAND THE INFORMATION THAT I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ALL WILL BE HELD IN THE UTMOST OF CONFIDENCE. I ACCEPT FULL RESPONSIBILITY FOR ANY CHARGES NOT COVERED BY MY INSURANCE.

_____

Signature Date

Secondary Insurance

Name of Insurance:_____ Phone #_____

Name of Policy Holder _____

First Last

Policy Holders DOB: _____ Policy Holder SSN:_____

Group #:_____ Policy #:_____

Policyholder Employer:_____

I UNDERSTAND THE INFORMATION THAT I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ALL WILL BE HELD IN THE UTMOST OF CONFIDENCE. I ACCEPT FULL RESPONSIBILITY FOR ANY CHARGES NOT COVERED BY MY INSURANCE.

_____

Signature Date

UC SMILES ORTHODONTICS APPOINTMENT POLICY

Thank you for trusting us with your orthodontic treatment. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. We know that life can get busy and emergencies happen. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible. We ask that you reschedule no later than 24 hours prior to your appointment time, this gives us time to schedule other patients on our waitlist.

Please read and initial our new NO SHOW/CANCELLATION POLICY below:

- _____: Effective April 1, 2022 any established patient who fails to show, cancel, or reschedule an appointment that has not contacted our office with **at least 24 hours notice** will be charged a **$25.00 fee.**

- _____: We have a 15 minute grace period if you are running late to your appointment, after the **15 minutes is up you will be charged the $25.00 fee and your appointment will have to be rescheduled.**

- _____: The $25.00 no show fee will be charged at **maximum 3 times** during your orthodontic treatment. **After the third time** the fee will go **up to a $50.00 charge.**

- _____: This fee will automatically be charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit in order to be seen.**

- _____: As a courtesy to our patients, we send out text message reminders prior to your appointment. If you **do not** receive a reminder message, **the policy will still remain in effect.**

We do understand there may be times when an unforeseen emergency can occur and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office. You may contact us Monday - Thursday 8:00a.m.- 5:00p.m. (lunch at 12:00p.m. - 1:30p.m.). If you are unable to reach the office, please leave a message, and we will give you a call back as soon as possible. You can reach us at 210-658-2251 or 210-340-0995.

Print Patient Name: _____ Date: _____

Patient/Responsible Party **Signature**: _____ Date: _____

Our office has accounts with Facebook, Instagram, and Tik Tok. Please fill out the form below if you would approve or disapprove of yourself or your child to be posted on our social media platforms.

_____: **Yes!** I give permission to UC Smiles Orthodontics for my/my child's photographs and videos to be featured on your social media sites.

_____: **No**, I do not give permission to UC Smiles Orthodontics for my/my child's photographs and videos to be featured on your social media sites.

_____

Patient Name Date

_____

Patient/Guardian Signature Date