DR. CHRISTOPHER TROCKEL DDS, MS   DR. MARTIN TROCKEL DDS, MS

Patient Information

Patient's Legal Name: ____ Gender: M F
First Middle Last

Birthday: ______/_______/__________ Age: ___________ Primary Contact #: ________________________________
Mo Day Year

Home Address: _______________________________________ City: _______________ State: ________ Zip: ____________

General Dentist: __________________________________ Have you ever been to an orthodontist? Yes No

Who may we thank for referring you to Dr. Trockel? ____

Account Information

1) Parent/Guardian: ____ Relationship to patient: ___________________

Social Security #________-__________-______________ DOB:________________________

Address (if different than above): __________________________________ City: _____________ State: _______ Zip: ________

Email: ____ Cell #: __________________________________

2) Parent/Guardian: ____ Relationship to patient: ___________________

Social Security #________-__________-____________ DOB:________________ Cell #: _________-__________-___________

Address (if different than above): __________________________________ City: _____________ State: _______ Zip: ________

Emergency Contact: _____________________________ Relationship: _______________ Cell #: _______-________-____________

FINANCIAL & HIPAA POLICY

Thank you for choosing True Smile Orthodontics! The True Smile Orthodontics family is passionate about your oral health. Below you will find our financial policy, which we require that you read, agree to and sign before we begin any treatment.
Please note: returned checks will be subject to fees. In the event that we need to utilize a collection agency and/or legal assistance to collect, you will also be responsible for any of their charges.

If you have insurance:

-For your convenience, we will provide an insurance estimate and we will help process your insurance claims. However, there is no guarantee that your insurance company will pay the full amount estimated.
-Your insurance policy is a contract with you, your employer and your insurance company. True Smile Orthodontics is not a party to that contract.
-Your insurance company will typically pay within 30-60 days from the time of claim submission and will continue to make payments over the course of orthodontic treatment considering the plan is still in effect. If payment is not received or your claim is denied for any reason, **you are ultimately responsible to pay the balance.**
-True Smile Orthodontics is committed to providing the best orthodontic treatment for our patients and our fees are customary for the industry in our area. You are responsible for the agreed upon price regardless of your insurance company's arbitrary determination of the reimbursement rates for the procedure(s).
-We require that you pay the co-payment and deductible. You can pay with cash, major credit card or one of the third party financing options that we provide.

HIPAA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant and business office staff. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.
Communicating with our patients is an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs in regards to privacy issues please put them in writing for the office so that we may address your concerns.

Consent:

I have read, reviewed, understand and agree to the terms and conditions listed above. I authorize my insurance company to pay my dental and orthodontic benefits directly to my orthodontic office. I understand that ultimately payment for any dental services rendered by True Smile Orthodontics to myself or any of my dependents is mine and is due and payable at the time services are rendered unless previous financial arrangements are made. I further understand that a finance, rebilling, attorney fee and collection charge will be added to any overdue balance. By signing below I authorize True Smile Orthodontics to call me at any number I provide including calls or texts to mobile or similar devices for any lawful purposes.

____ ________________________
Patient Signature (Parent if minor) Date

Medical History

Patient Name: ____

Have you seen a physician or been hospitalized in the last two years (including pregnancy)? Y N

If yes, please explain: ____

Physician's name & phone number: ____

Do you take antibiotics before dental treatment and cleanings? Y N
Do you have any of these conditions: Artificial Heart Valve, Previous Infective Endocarditis, Damaged Heart Valves in Heart Transplant, Unrepaired Cyanotic CHD, Repaired CHD with Residual Defects? Y N

Allergies to anesthetics or drugs such as antibiotics, pain pills, sedatives, aspirin; **latex** or metals? Y N
If yes, please list: ____

Are you currently pregnant? Y N

If yes, when are you due? _________________

Y N High/Low blood pressure
Y N Tuberculosis, COPD or lung problems
Y N Hepatitis A, B, C or D
Y N AIDS or HIV
Y N Excessive bleeding or blood disorder
Y N Diabetes
Y N Dialysis What days? M T W Th F
Y N Asthma
Y N Artificial joint

Y N Heart attack or heart trouble
Y N Chest pain with exercise (angina)
Y N Stroke
Y N Thyroid disease
Y N Epilepsy, seizures or fainting
Y N Tumors, cancer, radiation treatment
Y N Psychiatric disorders
Y N Tobacco use How often? ________
Y N Drug/alcohol dependency

If yes to any of the above please indicate details: ____

____

Other conditions not listed above: ____

Please list any prescription or over the counter medications, vitamins or herbs you are taking: ________________________

____

Dental History

Y N Are you in any dental discomfort?
Y N Is your mouth frequently dry?
Y N Do your gums bleed when you brush or floss?

Y N Sensitivity to hot, cold, sweets or pressure?
Y N Do you grind your teeth?
Y N Are you missing any teeth?

How often do you brush? __________________________ How often do you floss? ________________________________

On a scale of 0-10, zero being the least and ten being the most, please rate the following:
How healthy is your mouth?: ______ Dental Anxiety: ______ How happy are you with your smile?: _____

I have read the above information and answered accurately. I will not hold True Smile Orthodontics responsible for any action taken or not taken because of errors or omissions I may have made on this form.

Patient/Guardian Signature: ____ Date: ______________________