

Mid Peninsula Orthodontics

Welcome to Mid Peninsula Orthodontics

Welcome to our office! Our goal is to make every visit pleasant and educational.
We like to teach good oral care that will enable you to have a healthy bite and a beautiful smile.

1 About You Today's Date: _____

Name: _____
LAST FIRST MI MR/MRS/MS/DR

I prefer to be called: _____

Birthdate: ____/____/____ Age: _____ Male/Female

E-mail address : _____

SS #: _____

Home Address: _____
Apt/Condo #

CITY STATE ZIP

Single Partnered Married Divorced Widowed Separated

Where and when are the best times to reach you?

Hm #: _____ Pager/Cell : _____

Wk #: _____ Ext: _____

Employer: _____

Employer's Address: _____

How Long there? _____ Occupation: _____

Whom may we **thank** for referring you?

Other family members seen by us? _____

General Dentist: _____

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Occupation: _____

Employer: _____

Wk #: _____ Cell #: _____

SS # Email: _____

3 Billing Information

Person(s) Responsible for Account: _____

Billing Address: _____

Relation: _____ SS#: _____

4 Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____

In the event of an emergency, is there someone who lives near you that we should contact?:

Name: _____

Relation: _____

Wk#: _____

Hm#: _____

5 Insurance for Dual Coverage

Insurance Co. Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Adult Coverage? Y / N

Subscriber _____ SSN _____

Subscriber B-day _____ Group # _____

Lifetime Ortho Benefit _____ Deductible? _____

Paid at what % _____ Paid Monthly/Quarterly ?

Insurance Information

Insurance Co. Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Adult Coverage? Y / N

Subscriber _____ SSN _____

Subscriber B-day _____ Lifetime Ortho Benefit _____

Paid at what % _____ Group # _____

Paid Monthly/Quarterly ? _____ Deductible? _____

5 Medical History

Your current medical health is: **Good Fair Poor**
 Are you currently under the care of a physician Yes No
 Please explain:

Are you taking any prescription/over-the-counter drugs? Yes No

Please List Each One:

For Women:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Weeks #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- Y N Anemia / Radiation Treatment
- Y N Artificial Bones / Joints / Valves
- Y N Arthritis/Osteoporosis/Bisphosphonates
- Y N Blood Transfusion
- Y N Cancer / Chemotherapy
- Y N Congenital Heart Defect / Heart Murmur
- Y N Diabetes
- Y N Difficulty Breathing / Asthma / Hayfever / Sinus
- Y N Emphysema / Glaucoma
- Y N Epilepsy / Seizures / Fainting Spells
- Y N Fever Blisters / Herpes
- Y N Have you taken Fen/Phen or Redux
- Y N Heart Attack / Stroke / Surgery / Pacemaker
- Y N Hemophilia / Abnormal Bleeding
- Y N Hepatitis / Jaundice / Liver Problems
- Y N High / Low Blood Pressure
- Y N Immunocompromised
- Y N Hospitalized for Any Reason _____
- Y N Kidney Problems
- Y N Mitral Valve Problems
- Y N Psychiatric Problems
- Y N Rheumatic / Scarlet Fever
- Y N Severe / Frequent Headaches
- Y N Sinus Problems
- Y N Tire easily
- Y N Tonsils or Adenoids Removed (age: _____)
- Y N Tuberculosis (TB)
- Y N Ulcers / Colitis
- Y N Venereal Disease

Please list any serious medical condition(s) that you have had:

Are you allergic to the following?

- Y N Aspirin
- Y N Codeine
- Y N Erythromycin
- Y N Penicillin
- Y N Metal / Plastics
- Y N Anesthetics
- Y N Latex
- Y N Tetracycline

Other: _____

6 Dental History

What are the main concerns that you would like orthodontics to accomplish?

Have you ever had/been evaluated for orthodontics? Y N

Have you ever had a serious / difficult problem associated with any previous dental work ? Y N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Y N

Your current dental health is: Good Fair Poor

Do you want to improve your smile? Y N

Do your gums ever bleed? Y N

Have you ever injured your: Mouth Teeth Chin

Do you have any speech problems? _____

Do you clench or grind your teeth? Y N

Do you generally breathe through your mouth? Y N
 while asleep? Y N

Do you snore or have restless sleep? Y N

Do you have excessive tiredness during the day? Y N

Do you have a family member with sleep apnea? Y N

Do you have any extra or missing permanent teeth? Y N

Do you have more than one bite? Y N

Do you have problems chewing gum? Y N

Do you have problems chewing sticky/chewy foods? Y N

Have your teeth changed in the last five years? Y N

7 I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

Signature

Date

Mid Peninsula Staff Signature

Date

Stacey D. Quo DDS, MS

Specialist in Orthodontics

965 High Street

Palo Alto, CA 94301

Tel: 650-328-1600

FAX: 650-327-6556

e-ml: stacey.quo@ucsf.edu

www.orthoquo.com

If you have orthodontic insurance benefits...

We will provide you with the insurance forms to help you maximize your orthodontic benefits. Please be sure to have the following information available so that we may direct payments to you:

- Insurance company name and full address
- Employer name and address
- Group number
- Insured person's full name, social security number and date of birth
- Insured person's main residential address
- If patient is a minor, name of school where they attend and in which city
- If dual coverage, who is primary and who is secondary?

When checking your benefits with the insurance company, please be sure to ask the following questions as some of the information may not be disclosed to you otherwise and may result in non-payment:

- What is the lifetime maximum and has any of it been paid out?
- Is there a deductible?
- Is there an age limit?
- Does the provider need to be in-network?
- How are benefits paid?
- Is it billed monthly, quarterly or automatically?
- If there is dual coverage, is there a "non-duplication" clause?

The information they provide you is not a guarantee of payment. They will review the insurance claim you submit to them before sending you a written explanation of benefits.

If you have a flexible spending account benefit...

Many employers offer a flexible spending account to their employees to help cover dental and medical expenses which fall outside of insurance benefits. Employees can set aside pretax dollars for these expenses, including orthodontic treatment. Most flexible spending accounts have an annual maximum dollar amount along with specific plan requirements. An important rule of flexible spending accounts is that the money which is allocated for the plan year must be used within that plan year. Any money which is not spent will be forfeited and lost. Furthermore, some plans require that the money be allocated on a monthly basis throughout the plan year as opposed to one lump sum payment. Please consult with your employer regarding specific plan requirements and restrictions.

If you have a flexible spending account that you would like to apply towards orthodontic treatment and you believe you or your child may need treatment soon, it is important to contact our office well in advance of either the enrollment period or the expiration of the plan year. We will be happy to evaluate any members of the family for which the monies have been or will be allocated. Advance notice will allow us to properly time orthodontic treatment so that you can take full advantage of your flexible spending account dollars. If you have any questions about flexible spending accounts or insurance, I can help you.

Sincerely,

Darlene Neu

Financial Coordinator

Stacey D. Quo DDS, MS

Specialist in Orthodontics
965 High Street
Palo Alto, CA 94301
Tel: 650-328-1600
FAX: 650-327-6556
e-m: stacey.quo@ucsf.edu
www.orthoquo.com