

***ALL PAGES ARE DOUBLE SIDED**

Cape Cod Braces
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6 Nells Way, Orleans, MA 02554
1 Technology Park Drive, Bourne, MA 02532
508-771-1415
capecodbraces@nemsinc.com



Patient Information (Confidential)

PATIENT

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: (_____) _____ Date of Birth: ____/____/____ Gender: Male / Female

How did you hear about us? Patient: _____

Other: _____

PARENT/ LEGAL GUARDIAN INFORMATION

Custodial parent(s) name(s): _____

Father/Mother

Step Father/Step Mother

Guardian

Last Name: _____ First Name: _____

SSN#: _____ - _____ - _____ Date of Birth: ____/____/____

Home Phone Number: (_____) _____ Cell Phone Number: (_____) _____

Occupation: _____ Employer: _____

Email Address (we offer email appointment confirmations): _____

Father/Mother

Step Father/Step Mother

Guardian

Last Name: _____ First Name: _____

SSN#: _____ - _____ - _____ Date of Birth: ____/____/____

Home Phone Number: (_____) _____ Cell Phone Number: (_____) _____

Occupation: _____ Employer: _____

Email Address (we offer email appointment confirmations): _____

Dental Insurance Information

Subscriber Name: _____ Relationship to Patient: _____

Primary Dental Insurance Company: _____

Employer: _____

Subscriber SSN#: _____ - _____ - _____ Subscriber ID #: _____

Group Number: _____ Subscriber Date of Birth: ____/____/____

If MassHealth:

Patient Name: _____ MassHealth ID #: _____

Medical History

PATIENT NAME _____ Date of Birth: _____ / _____ / _____

Is the patient currently under physician's care: YES NO Date of Last Visit: _____ / _____ / _____

Physician's Name: _____ Phone Number: (_____) _____

Are all immunizations current: YES NO

Have you ever been hospitalized: YES NO If yes, reason: _____

Are you currently taking medications, if yes please list:

Have you ever taken/had Fosamax Boniva Actonel Bisphosphonates Chemotherapy N/A

Women: Are you : Pregnant Trying to get pregnant Nursing Taking oral contraceptives N/A

Any Allergies: N/A

Aspirin Penicillin Codeine Acrylic Latex Nickel Sulfa Drugs

Local Anesthetics Others not listed: _____

Please check any conditions you may have below: N/A

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver/Kidney Disease | <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Issues/Murmur | <input type="checkbox"/> Steroid Therapy | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emotional/Psych Disorder | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> OTHER: _____ | | | |

Dental History

Has the patient been to the Dentist before: YES NO Where: _____

Date of Last Visit: _____ / _____ / _____ Is your water fluoridated: YES NO

Do you use Fluoride toothpaste: YES NO Mouth Rinse: YES NO

Does patient have or ever had braces: YES NO Do you want information about braces: YES NO

Do you have any of the following:

Sensitivity to hot or cold Sensitivity to sweet Sensitivity to biting Bleeding Gums
Swollen face or mouth

Pain in any of your teeth Loose Teeth Problems with previous dental care:

**TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT.
IF I EVER HAVE ANY CHANGES IN MY HEALTH, I WILL INFORM MY DOCTOR AT THE NEXT APPOINTMENT**

Patient/Parent/Guardian Signature

Date

Doctor Signature

Date

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APPOINTMENT CANCELLATIONS

As a courtesy, we make every effort to confirm your appointment one day in advance. However, it should be noted it is your responsibility to keep all appointments. We request a MINIMUM OF 24 HOURS to change or cancel an appointment. A fee may be incurred for all failed or late cancellations. For more than two failed or cancelled appointments you may be placed on same day only appointment basis.

MassHealth Patients: In keeping with MassHealth's policy regarding repeated failures to show for scheduled appointments, we will be notifying MassHealth of your appointment experiences, which may negatively affect your coverage status and continued inclusion in the MassHealth program.

DENTAL INSURANCE

If you have insurance coverage our team, as a courtesy, does their best to determine a proper **ESTIMATE** for you. Due to the many insurance companies and plans we cannot always predict the actual payments your insurance carrier will make. You are required to make payment of your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments, have a credit issued to your account for future services or may be eligible for a refund. By signing this form, I hereby authorize and direct payment of dental benefits from my insurance company to Cape Cod Braces.

If you have Masshealth coverage, please be aware if you have a lapse in your coverage, or a procedure is denied, you are responsible for any out of pocket expenses that incur. You are responsible for understanding the benefits provided to you.

AUTHORIZATION AND RELEASE

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payers and/or health practitioners.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read/received a copy of this office's Notice of Privacy Practices.

Patient/Parent/Guardian Signature

Date

Patient Name

PATIENT NAME _____

SOCIAL MEDIA CONSENT

We like to show off all the fun and great things that happen at Cape Cod Braces. Often times we do this on social media in the form of photographs or videos and include our patients and their families. Please let us know if we have your permission to post any photographs or videos that may include you or your child on various Cape Cod Braces social media sites. These may include (but are not limited to) Facebook, Google+, Twitter, and Instagram.

Please initial below

I consent to Cape Cod Braces social media usage [_____]

I do not consent to social media usage [_____]

ELECTRONIC COMMUNICATIONS ENCRYPTION WAIVER

When communicating via electronic media (e.g. email) HIPAA standards require us to utilize encryption technology for your privacy. To keep electronic communications private, we utilize third party encryption methods that typically require a password for viewing. If you prefer to avoid encrypting any emails that may contain private information and opt out of data encryption, please fill out the form below.

Please initial below

I authorize electronic encryption [_____]

I wish to opt out of electronic encryption [_____]

Patient/Parent/Guardian Signature

Date