E Line ORTHODONTICS

Yoon H. Chang, DDS, MS

Patient's Name: First _____Last_____

Gender: Male/ Female, DOB _____/_____/_____ Age: _____ Social Security number:_____

Home Address, City, State, Zip Code: _____

Phone (_____)_____ ___ Text (yes, No) Email:_____

School Attending: _____ Hobbies/Interests: _____

Occupation: _____ Home/Cell Phone: (_____)_____

Name of family dentist, phone number: _____

Who may we thank for referring you to our office? _____

<Account Responsible Party>

First Name: _____ Last Name: _____

Gender: M F Relationship with patient: _____ DOB: _____/____ /____ SSN: _____

Home Address: _____

Cell Phone: (_____)_____Email:_____

<Insurance>

Insurance Carrier: _____ Name of Policy Holder: _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security No. _____

Policy Number: _____ Group Number: _____

Do you have Orthodontic Coverage: Y , N Max _____ Age limit _____ Deductible _____

***** Initial Consultation: $75 for TMJ/ Alternative Surgical Cases (i.e. needing Condylography) otherwise, it will be billed to your dental insurance**

The Adult/Guardian who brings in a minor will be responsible for all copayments and deductibles. Your signature below indicates that You understand accept this policy. You herein authorize payment of dental benefits to the Doctor when an assigned claim is filed.

Patient/ Legal Guardian Signature: _____ Date: _____

If more than one, please specify Name: _____

Phone Number: _____ Relationship to patient _____

Findings Initial-Diagnostics

Name_____ **Date**_____

Main concern_____

Special Medical Analysis

Do you have or did you ever have an illness with regard to points 1-12?

	yes	no
1. Infections		
2. Cardio-vascular systems		
3. Respiratory systems		
4. Digestive systems		
5. Metabolic systems		
6. Allergies		

	yes	no
7. Urogenital problems		
8. Central nervous systems		
9. Psychological problems (theraphy)		
10. Rheumatic disease		
11. Hormonal disease		
12. Special problems		

		valuation	yes	no
1.	Do you have problems when you chew?			
2.	Do you have problems when you are talking?			
3.	Do you have problems in closing your teeth properly?			
4.	Are any of your teeth especially sensitive?			
5.	Do you have a problem when you open your mouth very wide?			
6.	Do your jaw joints make noise and if so, on what side?			
7.	Do you have pain in the area of your jaw joints?			
8.	Do you suffer from headaches?			
9.	Do you suffer from cramps or spasm in your head, neck or throat?			
10.	Do you have in general problems with your posture?			
	Occlusal Index	0.00		

		yes	no
11.	Have you ever had a serious accident?		
12.	Did you have one or more oral intubations?		
13.	Have you ever had orthodontic treatment or...		
14.	Have you had a treatment with a splint?		
15.	Are you grinding or pressing with your teeth?		
16.	Do you think that treatment is necessary?		
17.	Do you think that there is a serious disorder or illness?		

18. When was the last time you had dental treatment and what was done?

19. How would you describe your psychic behaviour?

☐ happy ☐ sad ☐ calm ☐ excited ☐ self-controlled ☐ lack of self control

Dental History Analysis – Occlusal Index

	Y	N	Details
1. Are you pregnant, possibly pregnant, or breastfeeding?			
2. Are you currently receiving treatment from a doctor, hospital or clinic?			
3. Do you suffer from allergies, including hay fever, eczema, any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods? Or have you got a history adverse effects to dental materials? Please give details			
4. Are you carrying a medical warning card?			
5. Do you suffer from bronchitis, asthma or other chest conditions?			
6. Do you suffer from fainting attacks, panic attacks, giddiness, blackouts or epilepsy?			
7. Do you suffer from heart problems; Have a pacemaker, angina, heart murmur, blood pressure problems or stroke? Have you ever had rheumatic fever? If so, which?			
8. Are you diabetic?			
9. Do you suffer from arthritis?			
10. Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?			
11. Do you suffer from any infectious diseases (including HIV and hepatitis)?			
12. Have you ever had liver disease (e.g. Jaundice, hepatitis) or kidney disease?			
13. Have you ever had Blood Refused by the Blood Transfusion Service? If so why?			
14. Have you ever had a bad reaction to general or local anesthetics?			
15. Have you ever had heart surgery or brain surgery? Which?			
16. Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jacob Disease (CJD), or received growth hormone treatment before the mid 1980s?			
17. Have you ever had radiation therapy to head or neck?			
18. Do you have a history of mental health problems?			
19. Do you now, or have you ever, suffered from any eating disorders?			
20. Do you suffer from Gastro-Oesophageal or Acid Reflux?			
21. Any other conditions not listed here?			
22. Do you take Bisphosphonate medication for your bones? Have you in the past? Are you likely to in the future? (for osteoporosis / steroid use / bone cancer / Padget's disease)			

3D Cone Beam CT Imaging
Consent/Acknowledgment/Release and Waiver of Scope of Services

Date:

I,_____, hereby consent to Dr. Yoon Chang at E Line Orthodontics to take 3D cone beam imaging on (patient name)_____ to provide tentative orthodontic treatment options.

I was explained that the ICAT 3D Cone Beam Imaging quick scan will produce a radiation dosage equivalent to 6-7 days of ordinary background average radiation. I further understand that the purpose of taking 3D imaging is to **ONLY provide orthodontic treatment option** and NOT a professional interpretation or diagnosis of any cranio-facial structures, surrounding soft tissue or associated pathologies.

In consideration of the waiver of all costs and services through Dr. Yoon Chang at E Line orthodontics, I do hereby, or on behalf of (patient name)_____, now and forever release and discharge Dr. Change, his agents, employees, professional corporation, insurers and assigns from any loss, costs, damages or expenses arising out of taking 3D Cone Beam CT Imaging, advice, diagnoses, and treatment by said Doctor, his/her agents or employees to Patient.

I further understand that by executing this form, and accepting the specific consideration as recited above, the patient and anyone claiming through or on behalf of patient will be forever foreclosed from any claim for damages arising out of orthodontic services, advice, diagnosis, and treatment by said Doctor, his/her agents or employees.

The terms of this form are to be kept confidential by me, and will not be disclosed to anyone without the written authorization of said Doctor or an order from a court of competent jurisdiction.

This form and the consideration recited herein is not and shall not be constructed to be an admission of liability on the part of anyone, including, but not limited to, said Doctor, his/her agents or employees.

There will be $250 fee for duplication of imaging and release. There's no co-pay to patient for taking this image however, it will be E Line Orthodontics' property which is not transferrable until his/her orthodontic treatment starts at E Line Orthodontics

Patient/ Legal Guardian Name: _____ Date _____

Signature: _____

Dental Record Release

E line Orthodontics recognizes the patient's right to confidentiality of protected health information as set forth in federal and Texas state law.
All releases based on this form are limited to records dated up to and including the date of the patient/responsible party's signature. A new authorization is necessary for release of information on care provided after the date of the patient/responsible party's signature, unless you (the patient or responsible party) state in the authorization to release future records of a specific test, specific clinic appointment, etc.

I, _____, hereby authorize the doctor and staff of E Line Orthodontics to release records or knowledge concerning my dental health to the referring doctor(s).

Name of Patient/Guardian _____ Date _____

Signature_____

Privacy Consent Form

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic consultation, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, demographic data, etc.) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

We may call, write, email or text to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, write, email or text to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will email you an appointment reminder and/or leave you a reminder message on your cell phone or home answering machine or with someone who answers your phone if you are not home.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and the changes may not be implemented prior to the effective date of the revised notice. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice. You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on the Consent. You have the right to review our office's privacy notice prior to signing this Consent; a copy will be given to you upon request.

Thank you for your cooperation. Please let us know if you have any questions.

Patient/ Legal Guardian Name: _____

Responsible Party Signature: _____