The Dental Specialists ORTHODONTICS

Patient Bill of Rights

- You have the right to be treated with respect, consideration, and dignity by doctors and team members in this dental practice.
- You have the right to privacy as it relates to your patient information and dental care. Patients shall be assured confidential handling of their dental and financial records and may approve or refuse their release, except when required by law.
- You have the right, to the degree known, to receive information regarding your dental diagnosis, treatment, prognosis, alternatives, associated risks, and the expected cost sufficient to assure an informed choice.
- You have the right to refuse participation in scientific research.
- You have the right to change dentists within the practice or transfer to another The Dental Specialists Orthodontics location.
- You have the right to be informed of the wide range of dental services available to you.
- You have the right to after-hours and emergency care should the need arise.
- You have the right to be informed of the payment/financial policy.
- You have the right to express grievances or make suggestions by submitting them in writing to:

The Dental Specialists Orthodontics
2200 County Road C West, Suite 2210
Roseville, MN 55113

Patient Rights and Responsibilities

The Dental Specialists Orthodontics endorses the Patient Bill of Rights, which is printed below.

Patients have the responsibility to:

- Be considerate of the privacy and rights of other patients and be respectful of the doctors and team members.
- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider for you and/or your children, and participate in his/her care.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Notify The Dental Specialists Orthodontics at least 24 hours in advance if unable to keep scheduled appointment(s).
- Understand and ask questions regarding treatment.
- Continue care with recommended appointments and follow through with after care instructions.

If you have questions, please call your dental practice.

Thank you for choosing The Dental Specialists Orthodontics.

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PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION					
Patient's First Name:		Middle Initial:		Last Name:	Today's Date:
Nickname:	Birth Date:	Age:	❑ Male ❑ Female	School:	Grade:
Street Address:		City:		State:	Zip:
Home Phone:		Cell Phone:		Email:	
Interests & Activities:				Names & Ages of Siblings:	
Whom may we thank for referring you to our practice?					

FINANCIAL/RESPONSIBLE PARTY INFORMATION			
RESPONSIBLE PARTY			
First Name:	Middle Initial:	Last Name:	
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Relationship to Patient:			
SECOND HOUSEHOLD (IF APPLICABLE)			
First Name:	Middle Initial:	Last Name:	
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Relationship to Patient:			

DENTAL INSURANCE INFORMATION		
POLICY 1		
Policy Holder:	Birth Date:	Employer:
Name of Insurance Company:	Group #:	Subscriber ID:
Social Security Number:		
POLICY 2 (IF APPLICABLE)		
Policy Holder:	Birth Date:	Employer:
Name of Insurance Company:	Group #:	Subscriber ID:
Social Security Number:		

DENTAL HISTORY					
Dentist's Name:			Last Dental Visit:		
Frequency of Dental Checkups:			Does the patient have any unfinished dental work?		
	YES	NO		YES	NO
Clenching / Grinding	❑	❑	Jaw Joint Clicking / Popping / Soreness	❑	❑
Muscle Soreness in Head / Neck	❑	❑	Speech Problems	❑	❑
Ringing in Ears	❑	❑	If Yes, is Patient Currently Being Treated?	❑	❑
Headaches	❑	❑	Which Sounds:		
Thumb or Finger Sucking / Nail Biting	❑	❑	Mouth Breathing	❑	❑

MAIN ORTHODONTIC CONCERNS			
❑ Crowding	❑ Prominent Teeth	❑ Jaw Pain or Discomfort	❑ Spacing
❑ Crooked Teeth	❑ Missing Teeth	❑ Overbite	❑ Underbite
❑ Prominent Lower Jaw	❑ Small Teeth	❑ Small Lower Jaw	❑ Finger or Thumb Sucking
❑ Open Bite	❑ Other:		
Has the patient had previous orthodontic care? ❑ Yes ❑ No Please specify:			
Patient's main concern about their smile:			

MEDICAL HISTORY					
	YES	NO		YES	NO
Abnormal Healing and/or Bleeding	❑	❑	Fainting / Dizziness	❑	❑
ADD / ADHD	❑	❑	Growth Disorder	❑	❑
AIDS / HIV+	❑	❑	Hepatitis	❑	❑
Asthma	❑	❑	If Yes, what type:		
Diabetes	❑	❑	Latex Allergy	❑	❑
Epilepsy / Seizures	❑	❑	Nasal / Sinus Congestion	❑	❑
Please describe medical conditions not otherwise specified:					
Is the patient in good health? ❑ Yes ❑ No			Is the patient under the care of a physician? ❑ Yes ❑ No		
Physician's Name:			Physician's Phone:		
Please list current prescribed medications:					
Please indicate any allergies:					
Please list any serious illnesses or past hospitalizations:					
Is the patient required to take an antibiotic before dental treatment? ❑ Yes ❑ No					
Please indicate if the patient has any special needs or concerns:					
Emergency Contact Name:			Phone:		
Relationship to Patient:					

Signature (parent's signature if a minor): ____ Date: ______________