THE DENTAL SPECIALISTS ORTHODONTICS

Patient Bill of Rights:

At The Dental Specialists Orthodontics, we endorse a patient bill of rights. We strive to provide patients with personalized, comprehensive and patient-centered care. Thank you for trusting us with your oral health and welcome!

At The Dental Specialists Orthodontics, you have the right:

- To be treated with respect, consideration, and dignity by all doctors and team members in the dental practice.
- To privacy as it relates to your personal 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.
- To the degree known, receive information regarding your dental diagnosis, treatment, prognosis, alternatives, associated risks, and the expected cost sufficient to assure an informed choice.
- To be given the opportunity to participate in decisions involving your dental care, except when such participation is not possible for medical reasons.
- To request an interpreter if necessary.
- To refuse participation in scientific research.
- To change dentists within the practice or transfer to another location.
- To be informed of the wide range of dental services available to you.
- To after-hours and emergency care should the need arise.
- To be informed of the payment/financial policy.
- To provide feedback, express grievances or make suggestions by verbally communicating them to a doctor or team member, through our patient satisfaction survey or by submitting them in writing to:

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

Patient Rights and Responsibilities:

As a patient, you have the responsibility to:

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

If you have any questions, please speak with your doctor or call your dental practice. We are here for you.

THE DENTAL SPECIALISTS ORTHODONTICS

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:		

(Continued on back)

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:					

Patients or parents/legal guardians are requested to advise us of any change in the patient's health history.

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