ADAY & COOMBS
ORTHODONTIC SPECIALISTS

2701 Missouri Avenue, Suite D
Las Cruces, NM 88011
(575) 522-1500 (800) 376-1500
Fax: (575) 521-1529
www.AdayCoombs.com

Patient Information

Date_____ Patient #_____

Patient Name _____ M____F____ Patient prefers to be called_____
Last First Middle

Address_____
Street City State Zip

Primary Phone _____ Birthdate_____ Social Security #_____

E-Mail Address _____

Family Dentist _____ Whom may we thank for referring you?_____

Relatives treated here _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

Primary Phone_____ Work Phone_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. yrs Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Spouse's Employer_____ Occupation_____ No. yrs Employed_____

Social Security #_____ Birthdate_____ Primary Phone_____

Emergency Information

Name of friend or nearest relative not living with you_____

Primary Phone_____ Work Phone_____

I certify that the information provided on this form is true and correct to the best of my knowledge.
I understand that where appropriate, credit bureau reports may be obtained.

*Signature*_____

CONFIDENTIAL
(For your personal records)
For Office Use Only

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Insurance Coverage and Billing

If you have an insurance plan that will pay a portion of your orthodontic treatment fees, we will be happy to assist you in claiming your benefits. The terms of your orthodontic benefit and the method of reimbursement are determined by your insurance company and your employer. We cannot guarantee the amount of your insurance benefit or the schedule in which it pays. Therefore, to facilitate the processing of your insurance claim, we request the following:

* If you intend to assign benefits to our office (allowing you to make payment arrangements on the expected balance due AFTER insurance benefits), please sign in the appropriate place below. Some insurance companies will only pay the orthodontist. In the event your insurance company sends the benefit to you, financial arrangements will need to be made on that amount.
* We will complete the claim form and provide your insurance carrier with the following:
  A description of the malocclusion and proposed treatment.
  Estimated treatment time.
  Cost of the treatment including retention and supervision, if applicable.
* You are financially responsible to the doctor for all services rendered - your insurance company is responsible to you.
* If you assign your insurance benefits to our office and choose the pay in full option, the discount will apply only to the portion of treatment fee that you will be paying.
* Please provide us with your insurance information by filling in the section below.

Primary Insurance

Policy Holder_____ SS# / ID#_____

Address_____ Birthdate_____
Street City State Zip

Phone Number_____ Dental Insurance_____

Employer_____ Medical Insurance_____

Secondary Insurance

Policy Holder_____ SS# / ID#_____

Address_____ Birthdate_____
Street City State Zip

Phone Number_____ Dental Insurance_____

Employer_____ Medical Insurance_____

I have read and understand the above information. By signing this document, I agree to those policies.

Signature _____ Date _____

PATIENT NAME: _____

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MEDICAL HISTORY

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

[ ] Heart Attack/Stroke
[ ] Cancer/Chemotherapy
[ ] Heart Murmur
[ ] Rheumatic Fever
[ ] HIV/AIDS
[ ] Heart Surgery/Pacemaker
[ ] Shingles
[ ] Mitral Valve Prolapse
[ ] Kidney Problems
[ ] Artificial Bones/Joints
[ ] Artificial Valves
[ ] Sinus Problems
[ ] High/Low Blood Pressure
[ ] Fever Blisters
[ ] Frequent Headaches
[ ] Currently Pregnant
[ ] Psychiatric Problems
[ ] Epilepsy/Seizures/Fainting
[ ] Diabetes/Tuberculosis (TB)
[ ] Drug/Alcohol Abuse
[ ] Venereal Disease
[ ] Hemophilia/Abnormal Bleeding
[ ] Ulcers/Colitis
[ ] Congenital Heart Defect
[ ] Anemia/Radiation Treatment
[ ] Asthma/Arthritis
[ ] Difficulty Breathing
[ ] Hospitalized for Any Reason
[ ] Hepatitis
[ ] Blood Transfusion
[ ] Emphysema/Glaucoma
[ ] None of the Above

Are you allergic to any of the following drugs?

[ ] Penicillin
[ ] Aspirin
[ ] Erythromycin
[ ] Tetracycline
[ ] Dental Anesthetics
[ ] Codeine
[ ] Latex
[ ] Amoxicillin
[ ] Sulfa
[ ] Ceclor
[ ] Metals
[ ] Other_____

Who is your Family Physician? _____

Are you under the care of a Physician for any medical problems? No_____ Yes_____

Do you need to be premedicated prior to any dental procedure due to heart murmur or any other medical problem? No_____ Yes_____ If yes, what medicine do you premedicate with? _____

Please describe your current Dental Health? Good_____ Fair_____ Poor_____

Last Dental Visit? _____

Do your gums bleed? No_____ Yes_____

Do you now or have you ever had any pain/discomfort in your jaw joint (TMJ/TMD)? No_____ Yes_____

Has your jaw ever made noise (pop or click) or ever locked open or closed? No_____ Yes_____

Have you ever had an injury to your: ***Mouth*** ***Teeth*** ***Chin*** *(Please circle)*

Have you ever been evaluated for Orthodontic Treatment? No_____ Yes_____

What are your main concerns that you would like Orthodontics to accomplish? _____

I understand that the information that I have given today is correct to the best of my knowledge, it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the Orthodontic Staff to perform any necessary Orthodontic services that I may need.

Signature Date Updated-Initial Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OVER

Aday & Coombs Orthodontic Specialists

Your Credit Report(s) and the Price You Pay for Credit

What is a credit report?	A credit report is a record of your credit history. It includes information about whether you pay your bills on time and how much you owe to creditors.
How do we use your credit report(s)?	We use information from your credit report(s) to set the terms of the credit we are offering you, such as the down payment and length of the contract. The terms offered to you may be less favorable than the terms offered to consumers who have better credit histories.
What if there are mistakes on your credit report(s)?	You have a right to dispute any inaccurate information in your credit report(s). If you find mistakes, contact Equifax Credit (www.equifax.com), which is the consumer reporting agency from which we obtained your credit report(s). It is a good idea to check your credit report(s) to make sure the information it contains is accurate.
How can you obtain a copy of your credit report(s)?	Under federal law, you have the right to obtain a copy of your credit report(s) without charge for 60 days after you receive this notice. To obtain your free report, contact Equifax Credit Information Services: By Telephone:_____ Call toll-free: 1-800-685-1111 By Mail:_____ Equifax Credit Information Svcs. P.O. Box 740241 Atlanta, GA 30374 On the Web:_____ www.annualcreditreport.com
How can you get more information about credit reports?	For more information about credit reports and your rights under federal law, visit the Federal Reserve Board's web site at www.federalreserve.gov, or the Federal Trade Commission's web site at www.ftc.gov.

I have read and understand this Pricing Notice: _____

Initial and Date