BEL AIR ORTHODONTICS

Stephen L. Godwin, DMD, DMSc
Practice Limited to Orthodontics

410-838-2244 **610 S. Main Street**
410-893-7493 fax **Bel Air, MD 21014**

Welcome To Our Office

The benefits of a happy, healthy smile are immeasurable! Comfort, function and self esteem are realistic objectives of orthodontic treatment. We hope to exceed your expectations as we pursue that goal. Please fill out these forms completely. The better we communicate, the better we can care for you.

About You

Today's Date:_____

Name: _____

Nickname:_____ ☐Male ☐Female

Date of Birth:_____/_____/_____ Age:_____

SS#:_____Marital Status:_____

Home #: _____Cell#: _____

Work #: _____ Email_____

Home Address: _____

_____

Employer:_____

Occupation:_____

Best places to reach you:_____

Other family members seen by us: _____

_____

Spouse Information

Name: _____

Employer: _____

Work #: _____(Ext.)_____

SS#: _____Date of Birth: ____/____/____

Person Responsible For Account

Name:_____

Billing Address:_____

_____

Home #: _____Work #:_____

Relationship to Patient:_____

SS#: _____ Date of Birth: ____/____/____

Employer:_____

Employer's Address:_____

_____

Your Dental History

General Dentist: _____

Address: _____

_____

Phone: _____Last Visit:_____

Have you ever had or been evaluated for orthodontic treatment? If yes, name and address of previous orthodontist: ☐ Yes ☐ No

_____

_____

Orthodontist's Phone: _____

Date of Last Visit: _____

Is your dental health good? If no, please explain: ☐ Yes ☐ No

_____

_____

Do you have periodontal disease? ☐ Yes ☐ No ☐ I do not know

What Are Your Concerns Regarding Your Smile, Bite and/or Teeth? _____

_____

How Did You Find Us and Who May We Thank For Referring You To Our Office?
(Please mark <u>all</u> boxes that apply.)

☐ My dentist or ☐ hygienist or dental assistant
☐ A family member was treated or is being treated here.
Please specify whom:_____
☐ My neighbor, friend, co-worker, teacher or family physician recommended you. Please specify: _____
_____
Saw your advertisement in ☐ Verizon or ☐ Yellow Book
☐ Our website ☐ Other website; please specify _____
☐ Google search ☐ Insurance Directory/Website
☐ School Presentation ☐ Church Bulletin
☐ Local Publication; please specify _____
☐ Facebook or other social media
☐Other, please explain: _____

CONTINUED ON BACK

Medical History

Are you in good health? ☐ Yes ☐ No If no, please explain:

_____

_____

Physician's name: _____

Physician's Phone: _____Last visit:_____

Please list all drugs you are allergic to: _____

_____

Are you allergic to latex ☐ nickel ☐ ?

Are you taking any prescription and/or over-the-counter drugs? ☐ Yes ☐ No If yes, please specify: _____

_____

Have you had any major changes in your health in the past year? ☐ Yes ☐ No
If yes, please specify:

_____

_____

Have you been hospitalized within the past year? If yes, please specify: ☐ Yes ☐ No

_____

_____

Do you need to be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No
If yes, please specify:

_____

Have you ever had a serious or difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you had an injury to your mouth, teeth or jaw? ☐ Yes ☐ No

For Women:

Are you pregnant? ☐ Yes ☐ No

If yes, trimester #_____

Are you post-menopausal? ☐ Yes ☐ No

Have You Ever Had Any Of The Following Medical Problems/Procedures?

Heart problems/murmur	Y	N	Heart disease	Y	N
Difficulty in breathing	Y	N	High blood pressure	Y	N
Difficulty in swallowing	Y	N	Rheumatic fever	Y	N
Difficulty in sleeping	Y	N	Hepatitis	Y	N
Persistent cough	Y	N	Herpes	Y	N
Sinus problems	Y	N	HIV/AIDS	Y	N
Frequent vomiting/nausea	Y	N	Syphilis/Gonorrhea	Y	N
Recent weight loss	Y	N	Thyroid Disease	Y	N
Dizziness/Fainting Spells	Y	N	Kidney Disease	Y	N
Seizures/Epilepsy	Y	N	Tumors/Cancer	Y	N
Joint Pain	Y	N	Radiation Treatment	Y	N
Blurred Vision	Y	N	Anemia	Y	N
Headaches	Y	N	Asthma	Y	N
Hearing Problems	Y	N	History of diabetes	Y	N
Emotional Problems	Y	N	Skin disorders	Y	N
Stomach Problems/Ulcers	Y	N	Learning difficulties	Y	N
Frequent mouth ulcers	Y	N	Speech difficulties	Y	N
Allergies	Y	N	Chewing difficulties	Y	N
Pain in jaw/head/neck	Y	N	Neck/jaw/head injury	Y	N

Have you ever experienced clicking sounds or pain of the jaw joints/muscles upon opening/ closing of the mouth? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you experienced any other serious medical conditions not list above? ☐ Yes ☐ No

If yes, please specify: _____

_____

_____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please feel free to ask.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical history. I authorize the doctors and staff at Bel Air Orthodontics to perform the necessary dental services associated with my orthodontic care.

_____
Signature Date

I understand that I am responsible for payment of services rendered.

_____
Signature Date

To receive updates on current events, contests and exciting news from Bel Air Orthodontics, please provide us with your email address. _____ (Your email address will be held in strictest confidence.)

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Dental Insurance Information

Do you have dental insurance? ☐ Yes ☐ No

If you have dental coverage, our staff is happy to assist you in verifying your coverage, filing your claims, and working with you to maximize your insurance reimbursement for covered services. While we are pleased to file dental claims on your behalf, we are not responsible for any limitations in coverage that may be included in your plan.

The following information regarding your coverage is required for filing of claims:

Primary Orthodontic Insurance

Insurance Co. Name:_____

Address:_____

Phone: _____Group #: _____ Policy #: _____

Policy Owner's Name: _____SS#:_____

Relationship to Patient:_____ Policy Holder's DOB:_____/_____/_____

Policy Owner's Address:_____Phone:_____

Employer: _____Employer's Address:_____

Effective Date of Coverage: _____

I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I certify that the information I have provided is true and correct to the best of my knowledge. I understand that it is my responsibility to advise Bel Air Orthodontics of any changes in my insurance coverage or policy information.

_____

Signature/Primary Policy Holder Date

Secondary Orthodontic Insurance

Insurance Co. Name:_____

Address:_____

Phone: _____Group #: _____ Policy #: _____

Policy Owners Name: _____SS#:_____

Relationship to Patient:_____ Policy Holder's DOB:_____/_____/_____

Employer: _____Employer's Address:_____

Effective Date of Coverage: _____

I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I certify that the information I have provided is true and correct to the best of my knowledge. I understand that it is my responsibility to advise Bel Air Orthodontics of any changes in my insurance coverage or policy information.

_____

Signature/Secondary Policy Holder Date

For Office Use Only

Patient Name:_____ Birthdate:_____

Address:_____ Phone:_____

Lifetime Maximum:_____ind. or fam. (circle)__ Payable @ _____% Used to date:_____ Waiting Period? Y/N, If yes:_____

Ded:_____ Paid yet?_____ Age Restrictions:_____ Who: Employee, Spouse, Dependents (circle)

Disbursement:_____% IP, AUTO or RE-SUBMIT (circle), MONTHLY or QRTLY or SEMI-ANNUALLY or ANNUALLY (circle)_____

_____

Records thru Ortho LTM or Preventative: Pan (CDT code D0330):_____ Ceph (CDT code D0340):_____

Photos (CDT code D0350):_____ Models (CDT code D0470):_____

Staff Name & Date:_____Ins. Rep. Name:_____

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Do you have medical insurance? ☐ Yes ☐ No

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The following information regarding your coverage is required for filing of claims:

Primary Medical Insurance

Insurance Co. Name:_____

Address:_____

Phone: _____Group #: _____ Policy #: _____

Policy Owner's Name:_____ SS#:_____

Relationship to Patient:_____ Policy Holder's DOB:_____/_____/_____

Policy Owner's Address:_____Phone:_____

Employer: _____Employer's Address:_____

Effective Date of Coverage: _____

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_____

Signature/Primary Policy Holder Date

Secondary Medical Insurance

Insurance Co. Name:_____

Address:_____

Phone: _____Group #: _____ Policy #: _____

Policy Owners Name: _____SS#:_____

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Employer: _____Employer's Address:_____

Effective Date of Coverage: _____

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_____

Signature/Secondary Policy Holder Date

For Office Use Only

Patient Name:_____ Birthdate:_____

Address:_____ Phone:_____

Lifetime Maximum:_____ind. or fam. (circle)__ Payable @ _____% Used to date:_____ Waiting Period? Y/N, If yes:_____

Ded:_____ Paid yet?_____ Age Restrictions:_____ Who: Employee, Spouse, Dependents (circle)

Disbursement:_____% IP, AUTO or RE-SUBMIT (circle), MONTHLY or QRTLY or SEMI-ANNUALLY or ANNUALLY (circle)_____

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Records thru Ortho LTM or Preventative: Pan (CDT code D0330):_____ Ceph (CDT code D0340):_____

Photos (CDT code D0350):_____ Models (CDT code D0470):_____

Staff Name & Date:_____Ins. Rep. Name:_____

BEL AIR ORTHODONTICS

STEPHEN L. GODWIN, DMD, DMSc, LLC
SPECIALIST IN ORTHODONTICS FOR ADULTS AND CHILDREN

CONSENT FOR PUBLICATION OF NAME AND/OR PHOTOGRAPH FOR USE BY BEL AIR ORTHODONTICS

CONTEST WINNER

Patient Giving Consent: Name: _____

Telephone: _____ E-mail: _____

To The Patient or Person Authorized to Give Consent:
Bel Air Orthodontics is proud of our patients and their accomplishment and we'd like to spread the news. By signing this form, you will consent to the use and publication of your name and/or photograph on the Bel Air Orthodontics' contest bulletin boards, website, Facebook page and/or local printed publication.

Signature: _____Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ (Please print)

Relationship to Patient: _____

Personal Representative's Signature: _____

Right to Revoke: You have the right to revoke this Consent at any time by giving Dr. Stephen L. Godwin written notice of your revocation. Please understand that revocation of this Consent will not affect any action Dr. Godwin took prior to receiving your revocation.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Consent for Publication, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

610 SOUTH MAIN STREET
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