Luciana Wiltse DDS, MS
12888 West Bluemound Road
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o 262.439.8233
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TrueSmile orthodontics & esthetics

Adult Patient Account Registration

Date ___/___/____

Patient's Name: _____ Nickname: _____
First Middle Last Name

Gender:_____ Birthdate_____ Age: _____ Marital status: _____

Address: _____email: _____
Street City State Zip

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Other family members/friends seen by our office _____

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

Party Responsible for Financial Account

Self___ Other___ Name and relation to patient_____

Dental History

Reason for Orthodontic Consultation _____

Have you consulted or had treatment by another orthodontist? N___Y___

If so, Who?_____ When? _____

Dentist's name/Dental Group _____Phone #_____

Do you have dental check-ups every 6 months? N___Y___ Last visit: _____

What is your oral hygiene regimen presently? _____

Do you have any dental work to complete? N ___Y ___

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- **Mark any of the dental conditions below that <u>you have had</u> or <u>currently have</u>:**

N___Y___ Persistent thumb / finger / tongue thrust habit

N___Y___ Grinding or clenching of teeth

N___Y___ Mouth breather

N___Y___ Frequent canker sores or cold sores

N___Y___ Tooth sensitivity (hot, cold, sweets, pressure)

N___Y___ Tooth color changes **If so, describe**_____

N___Y___ Loss or removal of permanent teeth **If so, describe**_____

N___Y___ Congenitally missing/extra teeth **If so, describe** _____

N___Y___ Replacement of missing teeth (bridge, implant, removable appliance)
If so, describe_____

N___Y___ Periodontal disease (gum and bone supporting disease)

Was treatment recommended? _____When? _____ By whom? _____

Was treatment performed? _____When? _____ With whom? _____

N___Y___ Individual or family history of head and neck cysts

N___Y___ Individual or family history of excessive growth of the lower jaw

N___Y___ Dental or teeth/facial trauma **If so, describe** _____

N___Y___ Temporomandibular Joint Dysfunction (TMD-pain, locking, headaches)

Was treatment recommended? _____ When? _____ By whom? _____

Was treatment performed? _____ When? _____ With whom? _____

Medical History

Physician's name/Medical Group _____

Phone #_____ Last visit: _____

Are you under a physician's care? N ___Y ___ For what reason? _____

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- **List all prescribed AND over-the-counter medication:**

  _____

- Have your ever OR are you currently taking OR scheduled to begin taking any biphosphonate medications (alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva), Aredia or Zometa? N____Y____
- Do you have any allergies? N____Y____ **If so, describe** _____
- Do you require antibiotic premedication before dental procedures? N____Y____
- Have adenoids or tonsils been removed? N ____Y ____ If so, at what age? _____
- **Women** - Are you pregnant or think you may be pregnant? N____Y____
- **Mark any medical conditions below that <u>you had</u> or <u>currently has</u>:**

N ____Y ____ Anxiety/Depression	N____Y____ Eating disorder
N____Y____ Arthritis	N____Y____ Endocrine/Thyroid disorder
N____Y____ Asthma	N____Y____ Fainting/Seizures/Epilepsy
N____Y____ Bleeding disorder	N____Y____ GI disorder
N____Y____ Bone/Joint disorder	N____Y____ HIV/AIDS
N____Y____ Heart Disorder	N____Y____ High/Low blood pressure
N____Y____ Immune disorder	N____Y____ Kidney disorder
N____Y____ Cancer/Chemo	N____Y____ Lung disorder
N____Y____ Diabetes	N____Y____ Liver disease/Hepatitis
N____Y____ Vision, hearing, speech disorder	

- **Please list any other medical conditions or surgeries:**

_____

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Insurance Information

Dental insurance is meant to be an aid in receiving dental care by reducing your costs. Most insurance companies have a lifetime orthodontic benefit separate from regular dental coverage. As a courtesy, we will submit claims on your behalf.

Our office will obtain a pre-treatment estimate. This pre-treatment estimate was quoted by your insurance company and is assumed to be accurate. However, this is not always the case. The actual reimbursement can only be known after the service has been provided and the charges are submitted to your insurance.

Primary Dental Insurance Information

Policy Holders name: _____ Birthdate_____
First Middle Last Name

Policy Holders Address: _____Relation to patient: _____
Street City State Zip

Insurance Company: _____ Provider Services Phone#: _____

Group #: _____ ID#: _____ SSN: _____

Insurance Address: _____

Secondary Dental Insurance Information

Policy Holders name: _____ Birthdate_____
First Middle Last Name

Policy Holders Address: _____Relation to patient: _____
Street City State Zip

Insurance Company: _____ Provider Services Phone#: _____

Group #: _____ ID#: _____ SSN: _____

Insurance Address: _____

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RELEASE OF ACCOUNT INFORMATION

1- PHI and Notice of Privacy Practices

TrueSmile orthodontics is required by law to maintain the privacy of Protected Health Information or PHI, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of PHI. This notice is called **"Notice of Privacy Practices"**, which states how we may use and/or disclose your health information

Check below your preference regarding the **"Notice of Privacy Practices"**

____ I elect to NOT receive the **"Notice of Privacy Practices" OR**

____ I elect to receive a copy of **"Notice of Privacy Practices"**

2- Release of Medical and Dental Information

I have answered the above medical and dental questions in an accurate manner.I authorize Luciana Wiltse, DDS, MS to perform a complete orthodontic evaluation.

You have my permission to further inquire the respective care providers listed above and to release medical, dental, and personal information, regarding the condition, diagnosis, or proposed treatment.

I will notify TrueSmile orthodontics of any changes in my medical and dental health status, including changes in medications and allergies.

3- Financial and Insurance Information

I authorize my insurance carrier or any other third-party administrator to pay for the dental/ orthodontic insurance benefits otherwise due and payable to me directly to: TrueSmile orthodontics or Luciana Wiltse, DDS, MS.

I understand that I am responsible for all costs of orthodontic treatment that are not covered by my dental/orthodontic insurance

Patient Name (Print) _____

Parent Signature _____ Today's date___/___/_____