Luciana Wiltse DDS, MS
12888 West Bluemound Road
Elm Grove, Wisconsin 53122

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info@truesmilewi.com
o 262.439.8233
f 262.439.8246

TrueSmile orthodontics & esthetics

Child Patient Account Registration

Date ___/___/____

To provide the best service possible, we ask you to fill out this account registration form. We provide the highest level of confidentiality with respect to the collection and disclosure of all patient's personal information that is provided to us.

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

Birthdate: _____ Age: _____ Gender: _____

Address: _____
Street City State Zip

Home phone: _____Cell phone:_____ email:_____

School: _____ SchoolCity: _____ Grade: _____

Hobbies:_____

Other family members/friends seen by our office _____

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

Patient lives with

Both Parents___ Mother___ Father___ Guardian___ Other___ Relation to patient_____

Party Responsible for Financial Account

Both Parents___ Mother___ Father___ Guardian___ Other___ Relation to patient_____

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Father's name: _____ Birthdate: _____
First Middle Last Name

SSN: _____ Marital status: _____ email: _____

Address: _____
Street City State Zip

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

Employer: _____ Occupation: _____

Mother's name: _____ Birthdate: _____
First Middle Last Name

SSN: _____ Marital status: _____ email: _____

Address: _____
Street City State Zip

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

Employer: _____ Occupation: _____

If "Guardian" or "Other", please complete information below:

Name: _____ Birthdate: _____
First Middle Last Name

SSN: _____ Marital status: _____ email: _____

Address: _____
Street City State Zip

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

Employer: _____ Occupation: _____

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Dental History

Reason for Orthodontic Consultation _____

Is the child anxious about receiving orthodontic treatment? N___Y__

Have you consulted or had treatment by another orthodontist? N___Y_____

If so, Who?_____ When? _____

Dentist's name/Dental Group _____Phone #_____

Does the child have dental check-ups every 6 months? N___Y___Last visit: _____

What is the child's oral hygiene regimen presently? _____

Does the child have any dental work to complete? N ___Y ___

- **Mark any of the dental conditions below that <u>child has had</u> or <u>currently has</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_____

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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

If so, describe _____

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

If so, describe_____

N___Y___ Dental or facial trauma (teeth, jaw, head injuries)

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: _____

Is the child under a physician's care? N ___Y ___ For what reason? _____

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

  _____

- Does the child have any allergies? N___Y___ **If so, describe** _____
- Is antibiotic premedication required before dental procedures? N___Y___
- Have adenoids or tonsils been removed? N ___Y ___ If so, at what age? _____
- Has puberty been attained? N ___Y ___ If so, at what age? _____

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Mark any medical conditions below that <u>child has had</u> or <u>currently has</u>:

N ____Y ____ Anxiety/Depression

N____Y____ Arthritis

N____Y____ Asthma

N____Y____ Bleeding disorder

N____Y____ Bone/Joint disorder

N____Y____ Heart Disorder

N____Y____ Immune disorder

N____Y____ Cancer/Chemo

N____Y____ Diabetes

N____Y____ Vision, hearing, speech disorder

N____Y____ Eating disorder

N____Y____ Endocrine/Thyroid disorder

N____Y____ Fainting/Seizures/Epilepsy

N____Y____ GI disorder

N____Y____ HIV/AIDS

N____Y____ High/Low blood pressure

N____Y____ Kidney disorder

N____Y____ Lung disorder

N____Y____ Liver disease/Hepatitis

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

_____

- Are there any other behavioral/learning challenges that you feel we should be aware of? Special needs? ADHD? Physical restrictions? Auditory or visual challenges? Autism? **If so, please describe:**

_____

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Insurance Information

INSURANCE BENEFITS

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 about the 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 child's 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

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Today's date___/___/_____