ORTHODONTIC ACQUAINTANCE CARD

DATE _____ 20 ____

DATE OF BIRTH _____ AGE _____ SEX _____

PATIENT'S NAME _____ PHONE _____
Last First Middle Initial

ADDRESS _____ HOME CELL _____
Street City State Zip

SCHOOL _____ GRADE _____ REFERRED BY _____

PATIENT'S DENTIST _____ PHYSICIAN _____

PATIENT'S ORAL SURGEON _____

FATHER'S NAME _____ CELL PHONE _____

OCCUPATION _____ EMPLOYED BY _____

BUS. ADDRESS _____ BUS. PHONE _____

MOTHER'S NAME _____ CELL PHONE _____

OCCUPATION _____ EMPLOYED BY _____

BUS. ADDRESS _____ BUS. PHONE _____

NAMES AND AGES OF OTHER CHILDREN IN FAMILY _____

_____

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? _____ Yes ☐ No ☐

DOES PATIENT HAVE ANY PRIOR OR CURRENT HISTORY OF MAJOR ILLNESS? _____ Yes ☐ No ☐

PLEASE LIST: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

DIABETES ☐	TUBERCULOSIS ☐	ENDOCRINE PROBLEMS ☐
PNEUMONIA ☐	ANEMIA ☐	PROLONGED BLEEDING ☐
HEART TROUBLE ☐	EPILEPSY ☐	FAINTING OR DIZZINESS ☐
RHEUMATIC FEVER ☐	ASTHMA ☐	NERVOUS DISORDERS ☐
BONE DISORDERS ☐	KIDNEY INVOLVEMENT ☐	LIVER INVOLVEMENT ☐

DOES THE PATIENT HAVE TENDENCY TO COLDS? ☐ SORE THROATS? ☐ EAR INFECTIONS? ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ Yes ☐ No ☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS: _____

_____

LIST ANY ALLERGIES OR DRUG SENSITIVITY: _____

HAS THE PATIENT REACHED PUBERTY? GIRLS - HAS SHE STARTED MENSTRUATION Yes ☐ No ☐

BOYS - HAS HIS VOICE CHANGED Yes ☐ No ☐

HEIGHT _____ WEIGHT _____

DENTAL HISTORY

HAS THERE BEEN ANY INJURY TO THE FACE, MOUTH OR TEETH? _____ Yes ☐ No ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ Yes ☐ No ☐

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ Yes ☐ No ☐

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? _____ WHILE ASLEEP? _____ Yes ☐ No ☐

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ Yes ☐ No ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____ Yes ☐ No ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ Yes ☐ No ☐

LIST ANY MUSICAL INSTRUMENTS PLAYED: _____

REASON FOR CONSULTATION _____

_____

_____

Parent's Signature

Dr. Michael B. Montanaro D.D.S., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATON

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME:_____

ADDRESS:_____
STREET CITY STATE ZIPCODE

TELEPHONE:_____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime by contacting:

CONTACT PERSON: Dr. Michael Montanaro

ADDRESS: 5294 Park Avenue, Bridgeport, CT. 06604-1018

TELEPHONE: (203) 371-0119 **FAX:** (203) 372-3700

EMAIL: dr.michaelmontanaro@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____ **Date**:_____

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

PERSONAL REPRESENTATIVE'S NAME:_____

RELATIONSHIP TO PATIENT:_____

*YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
(Include a completed Consent in the patient's chart)

Dr. Michael B. Montanaro D.D.S., P.C.

Practice Limited to Orthodontics

5294 Park Avenue
Bridgeport, CT 06604
Phone (203) 371-0119
Fax (203) 372-3700
montanaroorthodontics.com

Dear Valued Patient,

To Clarify Many Misconceptions Regarding Your Insurance:

*Treatment recommendations are based on your or your child's needs, not on your insurance or lack thereof.

*If you have orthodontic coverage included in your dental insurance, you must present insurance card or information for insurance company, so that we may be able to submit a claim in your behalf.

*We will provide you with a **estimate of benefits** (EOB), which takes anywhere between 4-6 weeks (longer if you do not provide all the information needed for our office to expedite your claim) to come from your insurance provider. However, you are fully responsible for any treatment performed, which may not be covered by insurance (replacement and/ or broken retainers, bleaching, bonding, etc.)

***Remember: Your benefits are a contract between you, your employer and your insurance company.**

*We will not be responsible for what your insurance will or will not cover.

*As a reminder, it is not our responsibility to keep track of your insurance changes or termination. Should you have a change in insurance benefits, please contact us or provide us with the new insurance information. If you are terminated or your insurance is cancelled, you are responsible for your balance, including what the insurance company owes. (For orthodontics, insurance should be kept for at least a minimum of 2 years to fully pay out benefit lifetime max.)

*As always, we will submit your orthodontic claim at no extra cost to you.

Patient or parent signature_____

Date_____/_____/_____