MEDICAL AND CONTACT INFORMATION

PATIENT INFORMATION (Confidential)

Name________________________________Birth date_________Address________________________________
City__________________Prov__________Postal Code________Home #______________Work #___________
Cell #_____________________Employer_______________________________Marital Status_________________
E-mail__________________________Gender_____________Emergency/Parent Contact __________________
Phone___________Alt Phone____________How did you hear about us?________________________________
If it was a Family/Friend or other, whom shall we thank for your referral?_______________________________

ACCOUNT INFORMATION

Who would you like your statements sent to?
Name______________________________Email________________________Phone Number_________________
Address____Postal Code___________

DENTAL INSURANCE ❑ Yes ❑ No

Primary Insurance

Sub name_____________________________________
Date of birth__________________________________
Place of work_________________________________
Insurance company____________________________
Group #______________________________________
Certificate #__________________________________

Secondary Insurance

Sub name_____________________________________
Date of birth__________________________________
Place of work_________________________________
Insurance company____________________________
Group #______________________________________
Certificate #__________________________________

Do you have or have had any of the following? Please check all that apply.

❑ AIDS/HIV	❑ Gastro-Intestinal Problems	❑ Radiation Therapy
❑ Anemia	❑ Head Injuries	❑ Respiratory Problems
❑ Arthritis	❑ Heart Disease/Angina	❑ Rheumatic Fever
❑ Artificial Joints	❑ Heart Murmur	❑ Rheumatism
❑ Asthma	❑ Hepatitis	❑ Sinus Problems
❑ Blood Disease	❑ High Blood Pressure	❑ Smoker
❑ Cancer	❑ Hip, Knee, or Joint Replacement	❑ Stomach Problems
❑ Diabetes	❑ Kidney Disease	❑ Stroke
❑ Dizziness	❑ Liver Disease	❑ Tuberculosis
❑ Drug/Alcohol Dependency	❑ Mental Disorders	❑ Thyroid Disease
❑ Epilepsy	❑ Pacemaker	❑ Tumors
❑ Excessive Bleeding	❑ Pregnant/Nursing	❑ Ulcers/Colitis
❑ Fainting	❑ Osteoporosis Medications And/ Or Bisphosphanates	❑ Sleep Apnea And/Or Snoring

Any other medical conditions not mentioned?____
____

ORTHODONTIC
SMILE STUDIO
235 The Boardwalk Suite 201
Kitchener, ON N2N 0B1
Phone: 226-929-8983
Email: info@orthodonticsmilestudio.com
Website: OrthodonticSmileStudio.com

MEDICAL AND CONTACT INFORMATION

Have you ever been hospitalized for any illness or operations? ❑ Yes ❑ No
If yes please explain____
Comments____
____

Name of your family physician_______________________________Phone#_______________
Do you smoke or have you ever smoked tobacco/cannabis? ❑ Yes ❑ No
If yes, how much (daily/weekly)_________________And for how many years?_____________
Are you taking any prescription or non-prescription drugs? ❑ Yes ❑ No
If yes please list:____
Are you allergic to any of the following?

Codeine	❑ Yes	❑ No
Penicillin	❑ Yes	❑ No
Local Anesthetics (dental freezing)	❑ Yes	❑ No
Latex	❑ Yes	❑ No
Other	❑ Yes	❑ No

If yes to other please list:____
Have you ever had any previous orthodontic treatment? ❑ Yes ❑ No
If yes please explain:____
____

❑ It is my responsibility to inform Orthodontic Smile Studio of any changes in my medical status. I authorize the dental staff to perform any necessary dental services during diagnosis and treatment with my informed consent. I authorize photographs and/or x-rays to be taken of me and placed in my file as part of my records. I agree that Orthodontic Smile Studio can collect, use and disclose personal information about me as set out in Ontario's Personal Health Information Protection Act (PHIPA). I authorize the release, to my insurance company or plan administrator, of the information contained in claims submitted electronically.

Signature_________________________Print Name_______________________Date__________

ORTHODONTIC
SMILE STUDIO
235 The Boardwalk Suite 201
Kitchener, ON N2N 0B1
Phone: 226-929-8983
Email: info@orthodonticsmilestudio.com
Website: OrthodonticSmileStudio.com

OUR FEES
At Orthodontic Smile Studio, we are committed to providing you with the most cost-effective option to achieve the best result for the treatment of your choice.

Our fees are designed to reflect the complexity of your individual case, the need for any additional orthodontic appliances and the length of treatment. These factors are determined by our careful clinical examination and inspection of your diagnostic records. However, we also streamline our fees to keep them at a reasonable level and in line with industry standards.

PAYMENT OPTIONS FOR PATIENTS WITH OR WITHOUT INSURANCE
Your oral health and your smile are yours forever, and we want to make it as easy as possible for you to receive the best orthodontic care in the most cost-effective way. This is why we offer no-interest payment plans to all of our patients, regardless if you have insurance. This consists of a non-refundable initial down payment that is due prior to the placement of the appliances, and monthly payments starting the following month on either the first or the fifteenth of each month. However, it is important to stress that **this monthly payment is a financing option that we provide as a service to our patients and is not a fee per appointment.**

We accept most major credit cards, debit cards and cash. Credit card details for monthly payments are required on or before the initiation of orthodontic treatment.

A 2% discount applies when accounts are paid in full, up-front.

Please note that monthly payments are due each month, even if appointments are not scheduled, missed or rescheduled.

The above fees are for orthodontic treatment only, and do not include dental appointments, extractions, fillings, exposure of teeth or any other dental work provided by another office.

Broken, damaged or lost appliances may require additional charges.

If you decide to change your treatment options once treatment has started, an additional fee will apply. For example, if you start Clear Aligner Therapy, but decide to switch to conventional braces, an additional fee to cover the cost of the fixed appliances will be charged prior to placement. Conversely, if you decide to switch from braces to Clear Aligner Therapy, a non-refundable lab fee will be due before delivery of the aligners.

Refunds will not be provided if you decide to stop treatment prior to its completion.

Any account that is 30 days overdue may be charged a late payment charge per month. If, for any reason, you cannot meet your payment schedule as outlined, please contact our office as soon as possible.

ORTHODONTIC
SMILE STUDIO
235 The Boardwalk Suite 201
Kitchener, ON N2N 0B1
Phone: 226-929-8983
Email: info@orthodonticsmilestudio.com
Website: OrthodonticSmileStudio.com

PAYMENT OPTIONS FOR PATIENTS WITH INSURANCE

Ultimately, all patients are responsible for full payment of their orthodontic treatment. However, as an added service to our patients, upon completion of your consult we will complete a financial contract and a Standard Information Form for you to submit to your insurance. Your insurance company will then be in touch with you to outline any orthodontic coverage that you may have and will reimburse you for any fees that were made payable to us.

❑ I have read and understood the Financial Policy of Orthodontic Smile Studio as outlined above. I agree that whether I have dental insurance or not, I am ultimately responsible for the cost of my dental treatment and that of all my dependent family members.

________________________________	__________________________________	______________
Signature of patient, parent or guardian	Print Name	Date

235 The Boardwalk Suite 201
Kitchener, ON N2N 0B1
Phone: 226-929-8983
Email: info@orthodonticsmilestudio.com
Website: OrthodonticSmileStudio.com

PATIENT CONSENT FORM

PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION YOUR PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality orthodontic care. We understand the importance of protecting your privacy, and we are committed to collecting, using and disclosing your personal information responsibly.

As dental professionals we are required to comply with Federal and Provincial Privacy Legislation, PIPEDA, and PHIPA to have each of our patient's sign a consent form allowing us to collect, use and disclose personal information according to specific guidelines.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in appropriate uses and protection of your information. Our office has a Privacy Code, which you may review at any time, and freely discuss with Dr. Höediono who is the Privacy Information Officer at this office.

In our office we will collect, use and disclose information about you for the following purposes:

- to assess your health needs and risks
- to enable us to contact you, including following up with treatment
- to offer and to provide treatment, care and service in relationship to the mouth and jaws, and dental care generally
- to communicate with other treating healthcare providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- to allow us to efficiently manage your account, including billing, debit and credit card payments, credit authorization, and for collection purposes
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act to permit potential purchases, practice brokers or advisors to evaluate the dental practice
- for teaching and demonstrating purposes on an anonymous basis
- to assist the office to comply with all regulatory requirements and comply generally with the law

I have reviewed the above information that explains why and how your office will collect, use and disclose my/ my child's personal information, and the steps your office is taking to protect this information. I know that your office has a Privacy Code and I can ask to see the Code at any time

❑ I agree that Orthodontic Smiles Studio – Dr. Caley Höediono can collect, use and disclose personal information about me/my child as set out above.

Patient's Name: ____ Date: ____________

____   ____

Signature of Patient, Parent, or Guardian   Signature of Witness

235 The Boardwalk Suite 201
Kitchener, ON N2N 0B1
Phone: 226-929-8983
Email: info@orthodonticsmilestudio.com
Website: OrthodonticSmileStudio.com