

ROBERT P. BUCK D.D.S., P.A.
ORTHODONTIC PATIENT INFORMATION

Patient's #: _____ (assigned by office) Age: _____ Birth date: _____ Sex: _____

Patient's Name: _____ SS#: _____

Home Address: _____
Street City St Zip Code

Home Phone: _____ Work Phone: _____ Cell: _____

EMERGENCY INFORMATION

Name: _____ Relation: _____

Address: _____ Phone: _____

Please fill out the orthodontic insurance you would like us to confirm at the new exam appointment.

INSURANCE INFORMATION

Subscriber's Name _____ ID/SS# _____

Subscriber's Address _____ Birth date _____

Employer _____ Group _____

Insurance Carrier _____ Phone# _____

If patient is covered by another dental plan, please complete the following:

Subscriber's Name _____ ID/SS# _____

Subscriber's Address _____ Birth date _____

Employer _____ Group _____

Insurance Carrier _____ Phone# _____

Referring Dentist: _____

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

I understand credit bureau reports will be obtained.

Signature _____ Date _____
(Responsible party signature required)

ROBERT P. BUCK D.D.S., P.A.

Patient: _____ Date: _____

MEDICAL HISTORY			
Family Physician: _____	Phone #: _____		
Has the patient ever had:			
Asthma	Diabetes	Heart Disease	Hepatitis
Anemia	Epilepsy	Hearing Disorder	Rheumatic Fever
Blood Disease	Endocrine Problems	Head or Face Injury	HIV
Bone Disorders	Emotional Problems	Herpes	Other (describe below)
Present drugs or medication: _____			
Has the patient been under the care of a physician during the past two years, other than for routine examinations? _____			

RESPIRATORY HISTORY			
Does the patient	_____		
Have allergies to:	Seasonal Grasses _____	Food _____	_____
	Drugs _____	Other _____	_____
Breath through mouth?	No Yes Sometimes	_____	
Tonsils removed?	No Yes When _____	Age _____	_____
Adenoids removed?	No Yes When _____	Age _____	_____

DENTAL HISTORY			
Family Dentist: _____	Phone #: _____		
Does the patient have pain or clicking in the jaw joint? No Yes (if yes, complete the TMJ section below)			
Have any teeth been injured due to accidents or blows to the mouth? _____			
Date of last dental check-up _____ Were the patient's teeth cleaned? No Yes			
Does the patient have any tooth sensitivity? _____			

ORTHODONTIC HISTORY			
Has the patient had a previous orthodontic consultation? No Yes Treatment? No Yes			
Date: _____		Doctor: _____	
Other family members with similar orthodontic condition: _____			

FAMILY HISTORY			
Brothers: _____		Sisters: _____	
Patient Living With: Mother Father Both Self Other: _____			
Other family member with similar orthodontic condition: _____			

TMJ					
Does the patient have:	Headaches	Neck Pain	Jaw Pain	Ear Pain	Facial Pain
Which side hurts?	Left	Right	Both		
Does it hurt to chew?	_____	Does it hurt to open wide?	_____	Does your jaw pop or click?	_____
Do you clinch or grind?	_____	Is it difficult to swallow?	_____	Painful?	_____
Has your jaw ever locked or slipped out of place? _____					
Do you have problems with your ears? _____		Hearing? _____		Dizziness? _____	
Other? _____					

Signature: _____
Updated (initial & date) _____

Dr. Robert Buck

7711 Garth Road
Baytown, TX 77521
281.427.2237
www.dr buck.com

Your Orthodontic Appointments

Patient's Name: _____
Last First Middle

In order to ensure quality orthodontic care, it is imperative that both parents and patients understand the manner in which we schedule your appointments. Our goal is to be the best part of your day. We make it a top priority to value both you and your time. That's why we make every effort to stay on or ahead of schedule. Most parents work and all children attend school. Inconveniencing your work schedule and interrupting your child's studies as infrequently as possible is very important to our entire office. Since the vast majority of our patients are of school age, it is unavoidable that some school-time appointments will be necessary.

If in the event you are not able to schedule your appointment before or after school/work hours we can schedule on the next School Holiday or next day off of work. In doing so, there is the possibility that treatment could be delayed.

We will be glad to work around certain classes that are very important or ones in which your child may be having problems. We provide your child with school excuses for scheduled orthodontic appointments and it is important for your child to turn these in to the appropriate school official within three (3) days..

We want you to know that our staff will work hard to provide the finest orthodontic care in the most convenient scheduling system possible for you and your child. We also have families and children and understand your scheduling concerns and will do everything we can to ensure that your child's treatment goes as smoothly as possible.

- **LONG APPOINTMENTS, BANDING AND BONDING:** These are more detailed and technique-sensitive appointments. Therefore, these appointments will be scheduled during our quieter morning hours.
- **SURESMILE APPOINTMENTS:** During the initial phase of treatment a 90-minute appointment will be required for an intra-oral bracket scan – this appointment is time and technique sensitive. Therefore, the appointment will need to be scheduled during our quieter morning or early afternoon hours.
- **EMERGENCIES:** (Pain, swelling, or bleeding) This usually results from trauma to the face or mouth. These patients will be seen as soon as possible and appropriate care given or referred to another specialist for treatment.
- **REPAIRS:** (Loose bands or brackets, broken arch wires or ties/broken appliances or retainers) These appointments are always scheduled during school hours at a specific time since they are long visits. The vast majority of your appointments over the course of treatment will be short appointments. By seeing our long-visit patients during school hours, it leaves more room in our schedule to see more patients after school hours.
- **APPOINTMENTS BROKEN OR NOT CANCELLED WITHIN 48 HOURS:** Another appointment will be scheduled but may require waiting 4 to 6 weeks. An appointment during school hours may be arranged sooner.

Thank you so very much for understanding!

I have read and agree to the scheduling information above:

Parent signature: _____ Date: _____



What You Should Know About Orthodontic Insurance

Orthodontic benefits are separate from dental benefits. Even though you are covered by dental insurance, you may not have orthodontic coverage. A plan booklet is generally available to you from your employer which describes the details of your policy and should outline any orthodontic coverage that might be available to you and your family. Familiarizing yourself with the details of your coverage may avoid misunderstandings later.

At your first appointment, it is often possible for our office to contact your insurance carrier to verbally confirm your orthodontic insurance benefit.

Eligibility

The requirements for eligibility vary by policy. Some policies require a waiting period for new employees, while others may require a specific number of hours to be worked per pay period to remain eligible. Orthodontic coverage in some cases is available only to dependant children under the age of 19. If you are unsure of eligibility requirements, you should refer to the plan booklet or contact the insurance administrator at your place of business.

How Benefits Are Calculated

There is no universal formula for calculating the amount to be paid toward the initial appliance placement fee or subsequent monthly fees. Each policy maintains its own formula. It is common for orthodontic benefits to be paid at 50% of the treatment fee to a lifetime maximum amount. Your policy may have a yearly deductible.

Flexible Benefits Plans and Executive Management Plans

Flexible Benefit Plans have become a very popular method of projecting "before tax" dollars to be spent during the next plan year. These types of plans commonly allow the insured to allocate a specified number of salary dollars toward certain expenses, usually medical, dental or child care expenses. Because these dollars are not subject to payroll taxes, they are a very attractive way of increasing the value of your "insurance dollars." In most cases, there are very specific rules about when orthodontic treatment is initiated to receive the greatest benefit. You must declare the amount to be spent for the year prior to the beginning of the plan year. The plan year for the policy may not be a calendar year. You stand to receive the greatest benefit by planning how orthodontic treatment can fit into the rules of your Flexible Benefit Plan. You may wish to confirm the beginning of the plan year.

What If I Have Multiple Coverage?

If the patient is covered by more than one orthodontic insurance policy, the carriers will determine which plan is considered the primary policy. Often this determination is made by birthdates of the insured parties. This method of determination is not a universal formula, but is individual to each carrier. The secondary insurance carrier will not declare or pay benefits until the primary carrier has made a determination of treatment that will be covered. The secondary carrier usually requires written confirmation from the primary carrier of the benefits to be covered.

How Our Orthodontic Office Can Help

Insurance benefits are coordinated between the insurance carrier and the insured. It is often helpful to you to know the extent of your insurance benefits when making financial arrangements. As a service to you we gladly accept most primary insurance benefits. To assist you, we are pleased to prepare insurance claims or provide other information required by your insurance company. **If insurance benefits are assigned to our office and your coverage changes or is lost, you will be responsible for any outstanding balance on your account.**

Signature of Patient/Guardian

Date

Robert P. Buck, D.D.S., PA
7711 Garth Rd.
Baytown, TX 77521

Provider ID # 60022
Phone: 281-427-2237
Fax: 281-421-4970

Credit Application

Identification Information

ID Type: Drivers License State-Issued ID Passport

ID #: _____

Expiration Date: ____ / ____ / ____

Please fill out applicant information below as completely as possible. The applicant is the patient, parent/guardian if patient is a minor, or veterinary owner. All fields marked with an * are required to process your application. If you already have a ChaseHealthAdvance Revolving Account or have questions, please call 1-888-519-6111.

Personal & Contact Information

First Name* _____ Middle Initial _____ Last Name*

Social Security #* _____ Date of Birth* ____ / ____ / ____ Home Phone #* _____ Other Personal Phone # _____

Mailing Address (Including Apt #)* _____

City* _____ State* _____ Zip* _____ Email Address _____

Street Address (Including Apt #) No PO Boxes _____

City _____ State _____ Zip _____

Income & Employment Information

Gross Annual Income*: \$ _____

Alimony, child support, or separate maintenance need not be included if you do not wish to rely on it. Gross Annual Income is income that you are able to use for repaying your debts. Examples may include income earned from salaries, investments, rental properties, Social Security benefits and retirement accounts.

Source of Income: Employed Self Employed Retired Other: _____

Residential Status: Own Rent Live with others Other: _____

Monthly Rent/Mortgage Payment*: \$ _____

Present Employer _____ Present Employer Phone # _____

Personal Reference or Relative Not Living with You _____ Phone # _____

I certify that: I am at least 18 years of age (19 in AL and NE). I have read and agree to all terms, conditions, authorizations and disclosures printed in the Legal Terms and Conditions brochure; I agree that the information submitted is true and correct; I authorize the submission of this instant credit application; and I have been given a copy of the Revolving Account Agreement that will govern my account, if approved, and I acknowledge that I should read it before using my account. Please sign to indicate your acceptance of the terms.

Applicant Signature: _____ **Date:** _____