HOLBERT family orthodontics

10200 Three Chopt Road, Suite B
Richmond, VA 23233
PH: 804-270-7824
info@holbertbraces.com

11847 Aspengraf Lane, Suite B
New Kent, VA 23124
PH: 804-966-3030
info@holbertbraces.com

Patient Information

- Please Print Clearly -

Patient's Name _____ Name Called _____

Birth Date _____ Sex ____ School _____Grade _____

Mother's Name _____Father's Name_____

Marital Status: _____ Child Lives With: _____

Address _____ City_____ Zip_____

Person Financially Responsible: _____

(Please circle best phone number for contact)

Home PH _____ Mom Cell _____ Dad Cell _____

Email Address: _____ (Used for Appointment Reminders)

How did you hear about us? Circle One: Dentist Friend Website Phonebook Other

Who can we thank for referring you? _____

Names and Birth Dates of Siblings: _____

Insurance Information

Orthodontic Insurance: _____ Policy Number: _____

Policy Holder's Name: _____ SS# _____Birth Date _____

Policy Holder's Employer: _____ Work PH _____

Secondary Carrier: _____ Policy Number_____

Policy Holder's Name: _____ SS# _____Birth Date_____

Policy Holder's Employer: _____ Work PH _____

HOLBERT family orthodontics

10200 Three Chopt Road, Suite B
Richmond, VA 23233
PH: 804-270-7824
info@holbertbraces.com

11847 Aspengraf Lane, Suite B
New Kent, VA 23124
PH: 804-966-3030
info@holbertbraces.com

Patient Health History

- Please Print Clearly -

Patient's Name _____ Sex: Male or Female

Name Called (Nickname) _____ Birth Date _____

Please list any sports, hobbies or musical instruments played: _____

_____

Dental History

Dentist Name _____ Date of Last Exam _____

Does the patient currently have any untreated/unfinished dental needs? YES or NO

Has the patient had an orthodontic consult or treatment? YES or NO If so, when? _____

Has your dentist taken a panoramic x-ray in the past year? YES or NO

Has the patient ever been treated for periodontal/gum disease? YES or NO If so, when? _____

What is the patient's main orthodontic concern? _____

_____

Please answer Yes or No to the following questions and explain as necessary

Speech problems/therapy?	Yes	No	Brush teeth twice daily?	Yes	No
Grind or clench teeth?	Yes	No	Floss teeth daily?	Yes	No
Oral habits (thumb/finger sucking)?	Yes	No	Mouth breathing?	Yes	No
Injury to face, jaw, teeth or mouth?	Yes	No	Snores during sleep?	Yes	No
Pain, tenderness or noise in jaw?	Yes	No	Requires premedication?	Yes	No
Unbalanced jaw size/growth?	Yes	No	Missing or extra permanent teeth?	Yes	No
Apprehensive about dental care?	Yes	No	Family history with orthodontics?	Yes	No

Please provide additional explanation as needed:

Medical History

- Please Print Clearly -

Physician's Name: _____ Date of Last Exam: _____

Address: _____ City: _____ Zip: _____

List any medications currently being taken by the patient: _____

_____

List any drug allergies or sensitivities the patient may have: _____

_____

Please answer Yes or No to the following questions and explain as necessary

Rheumatic Fever	Yes	No	Cancer	Yes	No
Tuberculosis/Lung Disease	Yes	No	Received radiation treatment	Yes	No
Pneumonia	Yes	No	Growth problems	Yes	No
Liver Disease	Yes	No	Endocrine problems	Yes	No
Kidney Disease	Yes	No	Hormone therapy	Yes	No
Heart Attack/Stroke	Yes	No	If female, pregnant or nursing	Yes	No
Heart Disease	Yes	No	Latex/Metal Allergy	Yes	No
Congenital Heart Defect	Yes	No	Nervous disorders	Yes	No
Heart Murmur	Yes	No	Bone disorders/Bone loss	Yes	No
Hemophilia	Yes	No	Diabetes	Yes	No
Hypertension/High Blood Pressure	Yes	No	Seizures/Epilepsy	Yes	No
Prolonged Bleeding/Transfusion	Yes	No	Handicaps/Disabilities	Yes	No
Anemia	Yes	No	Asthma	Yes	No
HIV/AIDS	Yes	No	Arthritis	Yes	No
Hepatitis	Yes	No	Treated for emotional problems	Yes	No
Tonsils/Adenoids Removed	Yes	No	Osteoporosis/Low bone density	Yes	No

Please explain any "Yes" responses from above:

Patients Under 18 years

Height: _____ Weight: _____ School: _____ Grade: _____

Birth Father's Height _____ Birth Mother's Height _____

Has patient begun puberty? Yes No

If female, has menstruation begun? Yes No If Yes, when _____

If male, has voice changed or facial hair appeared? Yes No

Has the patient grown significantly in the past year? Yes No

Patient's interest in orthodontic treatment: Excited Interested Indifferent Against

_____

Signature of Responsible Party: _____ **Date:** _____

HOLBERT family orthodontics

10200 Three Chopt Road, Suite B
Richmond, VA 23233
PH: 804-270-7824
info@holbertbraces.com

11847 Aspengraf Lane, Suite B
New Kent, VA 23124
PH: 804-966-3030
info@holbertbraces.com

COMMUNICATION WITH PATIENTS AND PARENTS: Open communication with our patients and their parents (if the patient is a minor) throughout orthodontic care is of utmost importance to us. We want and need you to feel comfortable discussing any questions or concerns with us at any time. There are many ways we can help each other.

- **SCHEDULING DIFFICULTIES:** If situations are **making it difficult to schedule** and keep regular appointments please let us know so that we can find a way to keep treatment progressing promptly.
- **INSTRUCTIONS:** If you need instructions repeated or re-explained, have any questions about **oral hygiene, appliance wear, progress or treatment concerns** please let us know.
- **E-MAIL**: If your **work schedule makes it difficult to call** during the day or you have something (in the case of a minor) you would like to discuss privately about your child's treatment, please feel free to e-mail our office at: **info@holbertbraces.com**
- The key to a successful relationship is a willingness to discuss concerns or difficulties. We cannot help if we are not aware that there is a problem. **Please let us know of any situation that might be affecting the quality of your orthodontic experience!**

COMMUNICATION WITH FAMILY DENTIST OF RECORD OR DENTAL SPECIALIST: Coordination of dental care and clear communication of orthodontic progress is important throughout treatment. Diagnostic letters and copies of x-rays will be sent to your dentist or any specialist involved in your case. Copies of letters of concerns about oral hygiene, appointment scheduling, cooperation or treatment progress will also be sent as needed. If you feel there are additional communication needs between the offices, please let us know.

COMFORT CARE OR BREAKAGE: Patient comfort throughout orthodontic care is our primary concern. Even the most careful patient can occasionally have loose or broken brackets or bands, have an o-ring/ligature come off or have problems with a wire. Our goal is to see patients in need of comfort care as soon as possible. With any appliance breakage we'd like to save you an extra trip. We will try to add time to an existing appointment or move the appointment to a time where the regular adjustment and breakage can be addressed together. The ways that you can help with this process include the following:

- ✓ Always **call ahead** even if you have an appointment scheduled that same day. Although tempting, just dropping in without an appointment will mean an unnecessary delay in being seen.
- ✓ **Give detailed information** about what is broken, loose or uncomfortable. Parents you may need to ask your child additional questions to be able to describe to us what the concern is.
- ✓ Please try to **be as flexible as possible** in terms of scheduling as your "ideal" time may not be available.

AUTOMATED APPOINTMENT REMINDERS: As a courtesy to our patients, we have invested in a computer automated appointment reminder system that can attempt to notify you by e-mail. Although we try to confirm every appointment, we cannot guarantee the system will always be successful in reaching you. We ask that you be responsible in noting each scheduled visit. Please let us know if you did not receive a reminder so that we can verify that your contact information is correct

Preferred Person and Method of Reminders

Contact Person: _____ **Relationship to Patient:** _____

☐ **Phone ( ) -** ☐ **E-mail:** _____

OUR SCHEDULING COMMITMENT TO YOU: We understand the value of your time and have worked hard to design a scheduling system that will allow us to: have the majority of appointments at "Patient convenient" times, see you on time for your appointments, have the correct amount of time to complete the necessary orthodontic adjustments, clearly explain any at-home instructions and fully answer any additional questions. **Ultimately, our goal is that scheduling concerns or difficulties not delay the completion of orthodontic care or have a negative impact on a patient's overall dental health.**

SCHEDULING-APPOINTMENT TIMES: As most of our patients are in school or work, we have put tremendous effort into designing a schedule that allows the majority of shorter, more regularly needed appointments to be made before or after school or work. Although infrequent throughout orthodontic care, **every** patient will have certain appointments (usually longer appointments) that can only be scheduled in the later morning or very early afternoon. If an excuse is necessary, we will be happy to provide one. For particular appointments no exceptions can be made.

CANCELLATION/MISSED APPOINTMENT: If an appointment cannot be kept, please attempt to notify our office at least **forty-eight** hours before the scheduled appointment so we may offer that time to another patient. Even when circumstances prevent calling forty-eight hours in advance, calling prior to the appointment will allow us to re-schedule the necessary appointment as promptly as possible. **A $50.00 fee** will be charged after two appointments are missed without advance notification from you. At the next scheduled appointment, we will sit down to discuss how future missed appointments can be avoided and how we can help.

RE-SCHEDULING: Our appointment times are typically scheduled six to twelve weeks in advance. To keep the treatment progressing satisfactorily, appointments that are missed or cancelled on short notice will be rescheduled in the next available appointment slot (most commonly found in the mid-morning or early afternoon slots.) Although your utmost flexibility will be needed in re-scheduling on short notice, after being seen for the re-scheduled appointment, we will make every effort to have future appointments scheduled into the time slots most convenient to you.

VISITING YOUR DENTIST: During orthodontic care, regular visits to the general dentist are an essential part of orthodontic treatment. These visits may be necessary every 3-6 months dependent on the recommendations of Dr. Holbert, the dentist or the hygienist. Regular dental visits are necessary for cleanings along with detection of cavities, bone or gum problems.

Certain problems, such as cavities or bone loss, can only be evaluated by special x-rays taken at the dentist's office. I understand that damage can occur to the teeth, bone and gum tissue if regular dental visits are not kept. I also understand that cleanings and diagnosis for cavities and periodontal disease are **NOT** part of the service provided by **Michael B. Holbert, D.D.S., P.C**. or any employee of the practice.

I also understand that Dr. Holbert has the right to remove the braces before orthodontic treatment is completed if the patient is not maintaining regular dental visits or if Dr. Holbert feels that additional damage will occur to the teeth if the braces are left in place.

USING A FLUORIDE RINSE EVERY NIGHT: It is very important that a fluoride rinse be used every night prior to going to bed. This is a recommendation of the American Association of Orthodontists based on years of research. The fluoride helps to protect the teeth, kill bacteria that can cause decalcification (permanent white marks on the tooth enamel) and rejuvenates the fluoride releasing glue used to hold the braces in place. Without the use of this fluoride, the risk of tooth damage increases, resulting in white spots, scars or cavities on the teeth.

Please make sure that the use of this fluoride is not discontinued during orthodontic treatment. Fluoride is not a substitute for good brushing but is a companion to good brushing. If the fluoride prescribed is not being used properly and Dr. Holbert feels that additional damage may occur to the teeth if treatment is continued, Dr. Holbert has the right to remove braces prior to completing orthodontic treatment.

I CERTIFY THAT I HAVE READ, UNDERSTAND AND DO AGREE WITH THE CONTENTS OF THIS FORM. I HAVE BEEN GIVEN THE OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED TO MY SATISFACTION. I FURTHER AGREE TO THE ORTHODONTIC TREATMENT AS OUTLINED BY THE DOCTOR.

Patient	**Responsible Party Signature**
Date	**Relationship to Patient**

If you have any questions, please let us know. We will be happy to help!

Michael B. Holbert, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____(Please Print Name)

_____(Signature)

_____(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____