Welcome to our practice!

Thank you so much for selecting Caudill & McNeight Orthodontics. We are very pleased to have you as a patient (insert our smiling faces here) and hope to make this a pleasant experience for you!

We are obsessed with prompt appointments and personalized, quality customer service. We openly welcome any questions or suggestions you may have. Here are a few important items to get you started with us.

What's in this packet?

Enclosed in this packet are all the medical, financial and other good-to-know bits of information about our practice. No worries, there won't be a quiz, but we do need for you to bring some important items to your first appointment.

Your First Appointment Checklist

Please bring the following items completely filled out and signed:

1. Medical/Dental History Form
2. Privacy Notice Sheet
3. Referral Information Sheet
4. Referral from your dentist (if you have one)

We're on Facebook & Instagram

Ok, so we admit we just love social media and like to have fun, so why not join in! See what we are up to by liking us on Facebook and following us on Instagram by searching 321ortho. We also occasionally run contests, fun promotions and events and would love to have you participate. Upload photos of you in your Caudill & McNeight Orthodontics t-shirt to win cool swag and even extra tokens that can earn you gift cards!

FREE Wifi - Both locations have FREE Wifi for you to surf the net and update your Facebook status during your visits. See you online!

Find us on Facebook or Instagram @321ortho. Check out 321ortho.com for more information!

Financial and Insurance Information

Your treatment at Caudill & McNeight Orthodontics is an investment that will last a lifetime. We understand that orthodontic treatment is a significant financial commitment. That is why we offer different payment plans and options to accommodate your financial budget.

Credit/Debit Cards

For your convenience, we accept MasterCard, Visa, Discover and debit cards.

Insurance

For those with orthodontic insurance benefits, our Financial Coordinator verifies, prepares and files the necessary paperwork. We will work with your insurance company to ensure that you receive all of your orthodontic benefits. By assigning your benefits directly to us, we will deduct these benefits from your remaining balance.

Please be aware, however, that our primary financial relationship is with our patients and their families and not with their respective insurance companies. Financial arrangements can be made based on your estimated insurance benefits, however, any outstanding insurance claims not paid are the responsibility of the patient/responsible party.

Please notify our office when you become aware that the insurance benefit has been discontinued or changed. We will notify you if we receive information about a change in benefits. Any amount of the estimated insurance benefit that the carrier does not pay will be added to your remaining account balance.

Financing Available

In-House Financing
Our in-house office financing offers an initial down payment with low monthly payments, interest-free with auto debit or credit from a financial institution.

Care Credit (3rd party financing)
Care Credit financing is also available with no interest, if paid within the promotional period of 6 or 12 months.

Pay-In-Full, Receive Additional Discounts

If you prefer to pay-in-full at the start of orthodontic treatment, additional discounts are given. We also offer a family discount on additional, immediate family members having orthodontic care with us. And who doesn't love a discount?

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CONFIDENTIAL

Medical/Dental History Form (Adult)

Date ________________

PATIENT

Patient's last name ______________________ First name ____________________ Middle initial _____

☐ Male ☐ Female

Prefers to be called ____________________________ Birth date ____________________________________

Home address ____

____

Home phone __________________________________Cell phone __________________________________

Occupation __________________________________ Employer __________________________________

Email address ____

DENTIST/PHYSICIAN

Dentist ____ Date last seen_________________________

Other dental specialists: Name/reason ____

Physician ____ Date last seen _________________________

Specialty physicians and specialty ____

GENERAL INFORMATION

What concerns you about your teeth? ____

How often do you brush? _________________________ Floss?__________________________________

Who suggested that you might need orthodontic treatment? ____

How did you hear about our office? ____

In the past have you consulted with another orthodontist? ☐ Yes ☐ No

Name/Date ____

Have you had any previous orthodontic treatment? Please describe. _________________________________

____

Orthodontist's Name/Date ____

Have any other family members been treated in this office? Please name them:

____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____

Address (if different from Page 1) ____

Home phone _________________________________Cell phone __________________________________

Email address ____

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DENTAL INSURANCE

Primary policyholder's full name ____

Birth date ______________________________ Social Security # ___________________________

Relationship to patient __________________ Employer ___________________________________

Insurance company _____________________________ Ins. Phone # _________________________

Group # ______________________________ ID # _______________________________________

Insurance claim address ____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policyholder's full name ____

Birth date ______________________________ Social Security # ___________________________

Relationship to patient __________________ Employer ___________________________________

Insurance company _____________________________ Ins. Phone # _________________________

Group # ______________________________ ID # _______________________________________

Insurance claim address ____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

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MEDICAL HISTORY

Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark Yes, No or Don't Know (DK) if you have or have had:

Yes	No	DK	
			Birth defects or hereditary problems?
			Any major injuries to the face, head or neck?
			Arthritis or joint problems?
			Cancer, tumor, radiation treatment or chemotherapy?
			Endocrine or thyroid problems?
			Diabetes or low sugar?
			Kidney problems?
			Stomach ulcer, hyperacidity, acid reflux?
			Immune system problems?
			History of osteoporosis?
			AIDS or HIV positive?
			Hepatitis, jaundice or other liver problems?
			Polio, mononucleosis, tuberculosis, pneumonia?
			Seizures, fainting spell, neurologic problem?
			Mental health disturbance or depression?
			History of eating disorder (anorexia, bulimia)?
			Frequent headaches or migraines?
			High or low blood pressure?
			Excessive bleeding or bruising tendency, anemia?
			Chest pain, shortness of breath, tire easily, swollen ankles?
			Heart defects, heart murmur, rheumatic heart disease?
			Angina, arteriosclerosis, stroke or heart attack?
			Skin disorder (other than common acne)?
			Vision, hearing, or speech problems?
			Frequent ear infections, colds, throat infections?
			Asthma, sinus problems, hay fever?
			Tonsil or adenoid condition?
			Do you currently have (or ever had) a substance abuse problem?
			Do you smoke or chew tobacco?
			Have you ever taken any medications to strengthen your bones?
			Have you ever taken oral or intravenous bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate), Zometa (zolendromic acid) or Aredia (pamidronate) for bone disorders, such as osteoporosis, osteopenia or cancer?
			Any other problems? Please Explain

Women- Are you: ☐ Pregnant ☐ Trying to become pregnant ☐ Neither

List any prescription medications, non-prescription medicines, herbal or supplements you take.

Medication ______________________ Taken for ______________________

Medication ______________________ Taken for ______________________

Medication ______________________ Taken for ______________________

Medication ______________________ Taken for ______________________

Medication ______________________ Taken for ______________________

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Have you ever had allergies or reactions to any of the following?

Yes	No		Yes	No	
		Local anesthetics (novocaine, lidocaine, ect.)			Latex (gloves, balloons)
		Aspirin or Ibuprofen (Motrin, Advil)			Acrylic
		Penicillin or other antibiotics- List below			Foods
		Metals (jewelry, clothing snaps)			Other-Please list below

Other allergies ____

DENTAL HISTORY

Now or in the past, have you had?

Yes	No	
		Supernumerary (extra) or congenitally missing teeth?
		Chipped or injured teeth?
		Any sensitive or sore teeth?
		Bleeding gums, bad taste or mouth odor?
		Jaw fractures, cysts, infections?
		Any teeth treated with root canals or pulpotomies?
		Frequent canker sores or cold sores?
		History of speech problems or speech therapy?
		Mouth breathing habit, difficulty breathing through the nose or snoring at night?
		Food impaction between the teeth?
		Frequent oral habits (sucking finger, chewing pen, etc.)?
		Teeth causing irritation to lip, cheek or gums?
		Abnormal swallowing (tongue thrust)?
		Tooth grinding or clenching?
		Clicking, locking in jaw joints?
		Soreness in jaw muscles or face muscles?
		Ringing in ears, difficulty in chewing or opening jaw?
		Have you ever been treated for "TMJ" or "TMD" problems?
		Have you ever been told to take antibiotics before dental treatment?
		Any lost or broken fillings?
		Any serious trouble associated with previous dental treatment?
		Have you ever been diagnosed with gum disease?
		Have you noticed any unusual changes to your face or jaws?

Is there any family history of:

☐Yes ☐No Unusual dental problems or congenitally missing teeth
☐Yes ☐No Jaw size imbalance or jaw surgery

Please explain: ____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dentist/dental specialists and dental insurance company.

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature ____ Date _______________

Orthodontist Signature ____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a
- copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient Name ____

____ ____________________

Patient /Parent or Guardian Signature **Date**

Referral Information

Thank you for choosing Caudill & McNeight Orthodontics! We know you have many options for orthodontic care and we truly appreciate your business.

So, how did you find our practice?

The greatest compliment we ever receive is for someone to refer us a new patient. Please bring this sheet with you to your appointment.

WORD OF MOUTH
If it's a human, we'd love to thank them personally!

Name: ____

How do you know them? ____
(i.e. One of our Patients – Dentist or Doctor – Friend – Family Member – Co-Worker – Neighbor – Other)

INTERNET
Please check any place you might have found us on the Interwebs.

___ Google

___ Invisalign.com

___ Yelp

___ Facebook

___ Instagram

___ Our website

___ Other website or social media ______________________________________

OTHER

___ Sports event or sponsorship

___ Print ad ____

___ Drive-by/ saw outdoor sign

___ Other ____

Thank you for your help. Your feedback is very much appreciated!

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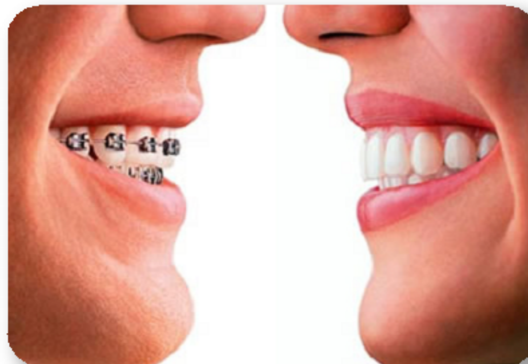
What's the Difference?

Braces		Invisalign	
(+/-)	Fixed to teeth, cannot remove	(+/-)	Removable for eating and oral hygiene
(+)	Compliance only required for hygiene and rubber band wear	(-)	Requires greater compliance
(-)	Must avoid eating hard, sticky and chewy foods	(+)	Eat and drink what you want
(-)	Appearance will change	(+)	Clear and virtually invisible
(-)	Additional time for cleaning teeth	(+)	Continue normal brushing and flossing
(-)	Higher risk of white spot decalcification with poor hygiene	(+)	Low risk of white spot decalcification
(-)	Broken or loose braces require additional appointments	(+)	Possibility of shorter and fewer appointments, if worn properly
(-)	Appointment intervals 6-10 weeks	(+)	Appointment intervals 10-12 weeks
(-)	Possibility of lip injury during sports	(+)	Great for active lifestyles
(-)	2-3 days of discomfort after braces adjustments	(+)	12-24hrs of discomfort from tooth movement with aligner changes
(-)	May be difficult for lips and tongue to adjust to braces	(-)	May be difficult for speech to adjust to aligner wear for a few days
(+)	Appropriate for all types of problems	(-)	May not be appropriate for a few types of problems



Please check the differences and choose what's best for you