Makers of great smiles.
ensleyortho.com

3810
sw hall boulevard
beaverton, oregon
97005

tel: 503-643-9509
fax: 503-646-2886

Welcome to our practice!

We appreciate your confidence in choosing us for your orthodontic care. We are committed to providing the highest quality care and a great experience for our patients. The result is beautiful, healthy teeth and a confident smile that will last a lifetime.

Your initial appointment will take approximately 75 minutes and begins with complimentary digital photographs and radiographs. We encourage you to invite your spouse, partner to be present for this appointment id applicable, so that decisions about treatment can be made.

Dr. Ensley will examine your teeth, mouth and profile. We will then give you a report with the following information:

- Identification of any orthodontic problems and their consequences
- Best customized treatment plan to correct the problem
- Estimated length of treatment time
- Best timing to begin treatment
- Fee for treatment, estimated insurance coverage, and personalized financial arrangements

The initial examination, photographs and 3D radiographs are complimentary.

Enclosed you will find an Information Form and HIPAA consent form to be completed prior to your appointment. Please bring these, as well as your insurance information (if applicable), with you to your appointment.

We look forward to meeting you!

Sincerely,

Garrett Peterson
New Patient Coordinator

ensley ORTHODONTICS
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tel: 503.643.9509 • fax: 503.646.2886
brace yourself. It's gonna be fun • ensleyortho.com

DATE _____
ACCOUNT NUMBER _____

Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help.

Patient Information

NAME (First & last)_____ AGE _____ DATE OF BIRTH_____ ☐ M ☐ F

ADDRESS_____ CITY _____ STATE _____ZIP_____

PATIENT PREFERRED NAME _____

HOME PHONE_____ MOBILE PHONE_____

EMAIL _____ WHAT'S THE BEST WAY TO GET AHOLD OF YOU _____

(SPOUSE IF APPLICABLE_____DATE OF BIRTH _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

PHONE_____ EMAIL _____

WHOM MAY WE THANK FOR REFERRING YOU_____

Responsible Party

☐ SAME AS ABOVE

PARENT/GUARDIAN_____DATE OF BIRTH _____

☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ OTHER

HOME PHONE_____ MOBILE PHONE_____ EMAIL_____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

PARENT/GUARDIAN_____ RELATIONSHIP_____DATE OF BIRTH _____

HOME PHONE_____ MOBILE PHONE_____ EMAIL_____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

IF DIVORCED PATIENT LIVES WITH: MOM _____ DAD _____ OTHER_____NAME _____

Dental Insurance Information

Primary Coverage

POLICY HOLDER NAME _____ DATE OF BIRTH _____

EMPLOYER _____ SOCIAL SECURITY # _____

INSURANCE COMPANY _____ GROUP NUMBER _____

ID NUMBER _____ PHONE _____

Secondary Coverage, if any

POLICY HOLDER NAME _____ DATE OF BIRTH _____

EMPLOYER _____ SOCIAL SECURITY # _____

INSURANCE COMPANY _____ GROUP NUMBER _____

ID NUMBER _____ PHONE _____

Emergency Information

NEAREST RELATIVE NOT LIVING WITH PATIENT_____RELATIONSHIP _____

HOME PHONE_____MOBILE PHONE _____

Authorization and Release

To the best of my knowledge the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for service. I understand that where appropriate, credit bureau reports may be obtained. I agree to be responsible for payment of all services rendered to me or my dependents.

Signature of patient (or parent if minor)_____

We are passionate about our mission to give everyone a great smile. Please help us help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, Bipolar, Autism, etc.

PATIENT PROFILE

[Y] [N] Does patient follow directions well?
[Y] [N] Does patient brush their teeth conscientiously?
[Y] [N] Does patient have learning disabilities or need extra help with instructions?
[Y] [N] Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

PATIENTS HEIGHT _____ MOTHER'S HEIGHT _____ FATHER'S HEIGHT _____

[Y] [N] Birth defects or hereditary problems?
[Y] [N] Any major accidents?
[Y] [N] Rheumatoid, osteoporosis or arthritic conditions?
[Y] [N] Diabetes?
[Y] [N] Cancer, tumor, radiation treatment or chemotherapy?
[Y] [N] Problems of the immune system?
[Y] [N] AIDS or HIV positive?
[Y] [N] Hepatitis, jaundice or liver problems
[Y] [N] Fainting spells, seizures, epilepsy or neurological disorders
[Y] [N] Mental health disturbance or behavioral problems?
[Y] [N] History of eating disorder (anorexia, bulimia)?
[Y] [N] Excessive bleeding or bruising tendency, anemia or bleeding disorder?
[Y] [N] Chest pain, shortness of breath or swelling angles?
[Y] [N] Cardiovascular problems (heart trouble, heart attack, angina)?
[Y] [N] Coronary insufficiency, arteriosclerosis, stroke, inborn heart defects
[Y] [N] Heart murmur or rheumatic heart disease?
[Y] [N] Eye, ear, nose or throat condition?
[Y] [N] Hay-fever. asthma, sinus trouble or hives
[Y] [N] Tonsil or adenoid conditions?
[Y] [N] Is the patient pregnant?

Allergies or reactions

[Y] [N] Local anesthetics (Novocaine or Lidocaine)
[Y] [N] Metals (jewelry, clothing snaps)
[Y] [N] Latex (gloves, balloons)
[Y] [N] Vinyl
[Y] [N] Other substances (specify) _____

Medications:

Is the patient taking medications, nutrient supplements herbal medications or non-prescription medications?
Please name them:
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
[Y] [N] Regular Anti-inflammatory use?
[Y] [N] Tobacco use?

FAMILY MEDICAL HISTORY

Does the patient parents or siblings have any of the following health problems? If so, please explain.

[Y] [N] Bleeding disorders _____
[Y] [N] Diabetes _____
[Y] [N] Arthritis _____
[Y] [N] Metabolic disturbance _____
[Y] [N] Severe allergies _____
[Y] [N] Unusual dental problems _____
[Y] [N] Jaw size imbalance _____
[Y] [N] TMJ disorders _____
[Y] [N] Any other medical conditions we should know about?
_____
_____
_____
_____
_____

DENTAL HISTORY

DENTIST _____ PHONE _____ DATE OF LAST EXAM _____

[Y] [N] Are you nervous about dental treatment?
[Y] [N] Do you require pre-medication for dental treatment?
[Y] [N] Do you have any sores or lumps in or near your mouth?
[Y] [N] Have you ever had any head, neck or jaw injuries?

If yes, please describe: _____

Do you have any ongoing problems in your jaw with:

[Y] [N] Chronic clicking or popping
[Y] [N] Pain?
[Y] [N] Difficulty opening or closing?
[Y] [N] Difficulty chewing?
[Y] [N] Do you clench or grind your teeth?
[Y] [N] Do you bite your lips or cheeks frequently?
[Y] [N] Have you ever had speech therapy?

If yes please describe _____

[Y] [N] Have you ever had instructions on the correct method of brushing and flossing your teeth?

[Y] [N] Have you ever seen an orthodontist?
[Y] [N] Did you or your parents have orthodontics?
[Y] [N] Do you have any of the following oral habits?
[Y] [N] Nail biting?
[Y] [N] Thumb sucking?
[Y] [N] Tongue thrust swallowing?
[Y] [N] Mouth breathing?
[Y] [N] Snoring?
[Y] [N] Sleep-apnea?
[Y] [N] How many times do you brush a day? _____
[Y] [N] (power or manual toothbrush)

Please check the boxes below which describe the problem(s) for which you are seeking treatment.

[Y] [N] Crowding
[Y] [N] Extra space
[Y] [N] Teeth stick out
[Y] [N] TMJ problems
[Y] [N] Poor bite relationship
[Y] [N] Missing teeth
[Y] [N] Teeth erupting in wrong place
[Y] [N] Second opinion for treatment
[Y] [N] What is your main concern?

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient / Parent Giving Consent

Patient Name _____

Personal Representative (if necessary): _____ Relationship: _____

Address: _____On File_____ Telephone: _____On File_____

Section B: To The Patient / Parent -- Please Read the Following Statements Carefully

Purpose of Consent: By signing the 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, or the uses and disclosure we may make of your protected health information and/or other important matters about your protected health information. A copy of our Notice is available at https://ensleyortho.com/uploads/pdf/Privacy_Practices_2011.pdf and in our office. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a Notice of Privacy Practices, which will contain the changes. These 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 any time by contacting:

Contact Person: Melanie Telephone: 503-643-9509 Fax: 503-646-2886
Address: 3810 SW Hall Blvd., Beaverton, OR 97005 Email: Melanie@ensleyortho.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 of 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.

Please sign only one of the acknowledgements below:

Consent: 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 your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date _____

Revocation of Consent: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature _____ Date _____