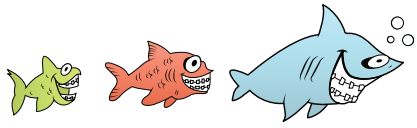
OUTER BANKS ORTHODONTICS



Acquaintance and History Questionnaire

Patient

Patient's Name _____ Nickname _____

Today's Date_____ Birthdate_____ Sex _____ Age _____

Address _____ City/State _____ Zip _____ Phone _____

School_____ Grade _____ Interest _____

Responsible Party (or Self)

Financially Responsible? ❒ Yes ❒ No Financially Responsible? ❒ Yes ❒ No

Self or Father's Name _____ Mother's Name _____

Address _____ Address _____

Do you: ❒ Own ❒ Rent How long?_____ Do you: ❒ Own ❒ Rent How long?____

Email Address: _____ Email Address: _____

Home Phone Number _____ Home Phone Number _____

Cell Number _____ Cell Number _____

SS Number _____ Birthdate:_____ SS Number _____Birthdate: _____

Occupation _____ How Long?_____ Occupation _____How Long? _____

Place of Business _____ Place of Business _____

Work Phone_____ Work Phone _____

Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Who has custody of the child? _____ Number of children in family? _____

Do You Have Orthodontic coverage with your Dental insurance? ❒ Yes ❒ No

If yes, please fill out Orthodontic Insurance form (attached)

I understand that there will be a credit bureau report obtained (soft credit check that will not affect your credit).

Signature (Parent signature if minor) _____ _____ _____

Updates (date & Initial) _____

Medical History

Name and Address of patient's physician _____

Present Health (circle) Good Fair Poor Date of Last Physical _____

Is Patient now receiving medication? Yes ❒ No ❒ If yes, for what? _____

Does the patient now have or has the patient had any of the following? Yes ❒ No ❒

Yes	No		Yes	No		Yes	No	
_____	_____	Rheumatic Fever	_____	_____	Diabetes	_____	_____	Hearing Problems
_____	_____	Heart Disease	_____	_____	Emotional Problems	_____	_____	Tonsils Removed
_____	_____	Bleeding Problems	_____	_____	Mental Deficits	_____	_____	Sinusitis
_____	_____	Hepatitis	_____	_____	Frequent Colds	_____	_____	T.B.
_____	_____	A.I.D.S.	_____	_____	Speech Problems	_____	_____	Asthma

Allergies Yes ❒ No ❒ If yes, list _____

Is your child taking any vitamins? Yes ❒ No ❒ If yes, list _____

Has your child had any unfavorable reaction or allergy to medication, such as penicillin, aspirin or local anesthetic?

Yes ❒ No ❒ If yes, list _____

Has your child ever been hospitalized? Yes ❒ No ❒ If yes, list _____

Dental History

Name and address of patient's general dentist _____

Has patient ever had a habit of sucking finger, thumb or other? _____

How severe? _____ How long? _____ When? (nights only, etc.) _____

Has patient had previous orthodontic care? Yes ❒ No ❒ If yes, when? _____

For how long?_____ Treated by whom? _____

When did patient last see dentist? _____ For what reason? _____

General Information History

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

What do you think is your/your child's biggest orthodontic problem? _____

Will payments be made by self, father, mother, or other? (circle) Do you have dental insurance? Yes ❒ No ❒

In separation or divorce situations, the individual who initiates services with us is held financially responsible.

Whom do we contact in case of emergency? _____

Consent: Your child is a minor. Therefore, it is necessary that a signed permission be obtained from a parent/guardian before any and/or all necessary orthodontic treatment can be started. Authorization is also necessary to release medical information to my physician if needed. Authorization is hereby granted as such.

I hereby certify that the information I have given is correct and true to the best of my knowledge. Furthermore, I give permission for the release of all information to any/all physicians, institutions or to any agency which may have an interest in the settlement of payments for services rendered. I further authorize direct payment to HA Dunlevy, DMD, MS, PLLC.

I agree to pay my account as it comes due and further agree that if I do not, I will pay all the expenses incurred in collecting the same, including court costs and a 33.3% attorney's fee.

I agree that a service charge of 1 1/2% per month or (18% per annum) will be added to account over 60 days delinquent.

I agree to provide HA Dunlevy, DMD, MS, PLLC with address and other information changes so that his office can properly send current bills to me.

Signature _____Date _____

H.A. Dunlevy, D.M.D., M.S., PLLC.
Outer Banks Orthodontics
2224 S. Croatan Hwy, Suite 7
Nags Head, NC 27959
252.441.6683

Orthodontic Insurance Information

In order to assist you in determining your orthodontic insurance benefit, the following information is necessary:

Patient Name: _____Date of Birth: _____

Policyholder: _____ Date of Birth: _____

Address: _____

Policyholder's SSN: _____ Phone: _____

Policyholder's Employer: _____

Insurance Company: _____ Policy/Group #: _____

Policy ID (Insured): _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

Is patient covered under another plan? If so, please complete the following information:

Patient Name: _____Date of Birth: _____

Policyholder: _____ Date of Birth: _____

Address: _____

Policyholder's SSN: _____ Phone: _____

Policyholder's Employer: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

I, hereby authorize release of any insurance information relating to this claim:

Signature: _____ Date: _____

I hereby authorize payment of insurance benefits directly to Outer Banks Orthodontics:

Signature: _____ Date: _____

Please notify our office of any changes in your insurance policy as soon as possible.

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AAOIC SUPPLEMENTAL INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as the "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes ❒ No ❒

Patient Name (Please print): _____

Patient/Parent Signature : _____

Date: _____

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Authorization for Release of Information

Patient Name: _____Date of Birth: _____

You have the right to request that Outer Banks Orthodontics communicate with you by alternative means or at alternate locations. This form is optional and does not expire. Your request will be in effect until you notify Outer Banks Orthodontics of a change in writing. We will accommodate all reasonable requests.

I _____ , hereby consent and state my preference to have my request that my medical and/or billing information be communicated to me by the following means (check all that apply):

❒ Home Phone _____

❒ You may leave a message/send texts with **medical information** on voice mail/answering machine

Cell Phone _____ Work Number _____

❒ You may leave a message/send texts with **appointment reminders** on voice mail/answering machine

Cell Phone _____ Work Number _____

❒ Email and/or text communication - I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Photos taken by staff (Example: Pre/Post Procedure) - Photos/xrays taken by our office may be mailed to patient guardian and/or dentist

❒ May be posted in office ❒ May be posted on our website (winning a contest or other activities

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SME messaging regarding my medical care might be intercepted and read by a third party.Outer Banks Orthodontics does not recommend the use of email or text messaging to communicate about my medical care and will not initiate communication with me via email or SMS messaging, unless sent through our secure portal.

Signature: _____ Date: _____

Please notify our office of any changes in your insurance policy as soon as possible.

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of
(Responsible Party)
Privacy Practices.

Patient Name: _____

Responsible Party Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, however acknowledgement could not be obtained due to:

❒ Individual refused to sign

❒ Communication barriers prohibited obtaining the acknowledgement

❒ An emergency situation prevented us from obtaining acknowledgement

❒ Other (Please specify): _____

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Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 _____

Print Patient Name: _____

Parent/Guardian and Relationship to Patient: _____

_____

Please note: It is helpful to list below any family members or persons that could be accompanying the patient to appointments. Also if there is SPECIFIC information you DO NOT want disclosed, such as financial information to anyone listed below, please notify our office HIPAA Compliance Coordinator, who can make additiona notations of this.

❒ I, _____ hereby authorize the following person/persons to receive health treatment and financial information regarding the above name patient. Please note: It is helpful to list below any family members or persons that could be accompanying the patient to appointments.

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

❒ NO, DO NOT DISCLOSE ANY TREATMENT INFORMATION (please initial here) _____

SIgnature: _____