

**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 “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/Parent’s Signature                      Date



**CRAWFORD ORTHODONTICS**  
CRAIG H. CRAWFORD, D.D.S.

*Patient Information Sheet*

Last Name: \_\_\_\_\_ M: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Nickname/Preferred to be called: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 School/Employer: \_\_\_\_\_ Grade/ Position: \_\_\_\_\_  
 Interests/Sports: \_\_\_\_\_

**Primary**  Mother  Father  Step Parent  Self  Other (specify) \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_ How Long? \_\_\_\_\_  
 Employer/Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Dental/ Orthodontic Insurance:  yes  no

**Secondary**  Mother  Father  Step Parent  Self  Other (specify) \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_ How Long? \_\_\_\_\_  
 Employer/Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number : \_\_\_\_\_

How Did You Hear About Us?  Dentist  Patient  Relative  Acquaintance  Other \_\_\_\_\_  
 Whom May We Thank for Referring You to Us? \_\_\_\_\_ Present Dentist: \_\_\_\_\_ Last Seen: \_\_\_\_\_  
 Reason For Consultation: \_\_\_\_\_

Check Yes or No for which the patient has a history:

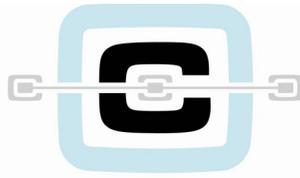
	Y	N		Y	N		Y	N		Y	N			
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Neck Aches	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Sicca	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Clicking of Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Taking Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful Chewing	<input type="checkbox"/>	<input type="checkbox"/>	TMJ/Jaw Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>	Immune Problems	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tooth Grinding	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>			
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>			

If allergies, specify \_\_\_\_\_ Any disease or problems not mentioned above? \_\_\_\_\_  
**Is medication required before dental visits?** \_\_\_\_\_ Current Medications? \_\_\_\_\_  
 Females: Have you started menstruating? \_\_\_\_\_ At what age? \_\_\_\_\_  
 Have wisdom teeth been extracted? \_\_\_\_\_ Any face, mouth or teeth injuries? \_\_\_\_\_  
 Does Patient normally breathe through the mouth while awake or asleep? \_\_\_\_\_ Do gums bleed when brushed or flossed? \_\_\_\_\_  
 Has an orthodontist been consulted previously? \_\_\_\_\_ Have you ever had previous orthodontic treatment? \_\_\_\_\_  
 Are there any missing or extra teeth? \_\_\_\_\_ Have the tonsils and adenoids been removed? \_\_\_\_\_  
 Any other questions? \_\_\_\_\_  
 Names and ages of brothers and sisters: \_\_\_\_\_

**\*\*Please notify us immediately if there are any changes to your medical history in the future\*\***

**Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## CRAWFORD ORTHODONTICS

CRAIG H. CRAWFORD, D.D.S.

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, \_\_\_\_\_, have read a copy of this office's Notice of Privacy Practices. (Please Print Patient or Guardian Name)

### PATIENT'S AUTHORIZATION OF TREATMENT

I hereby authorize Dr. Craig H. Crawford and any of his assistants to perform routine orthodontic procedures on

\* \_\_\_\_\_  
(Please Print Patient's Name)

\* \_\_\_\_\_  
(Signature of Patient or Guardian) (Date)

\* \_\_\_\_\_  
(Signature of Witness)

### Orthominder Authorization

Crawford Orthodontics will be confirming appointments by Orthominder. I hereby give the authorization to allow Crawford Orthodontics to use my e-mail address and/or cell phone to receive text messages to confirm appointments.

Email address: \_\_\_\_\_ Cell phone Number: \_\_\_\_\_

Cell phone provider: (AT&T, Sprint, Verizon)

Other: \_\_\_\_\_

Signature: \_\_\_\_\_

### Authorization to check credit

I hereby authorize OrthoBanc, LLC, on behalf of Crawford Orthodontic to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options. This credit check does not affect the credit score and is only done once orthodontic treatment is determined to be necessary and payment arrangements are being made.

SS#: \_\_\_\_\_

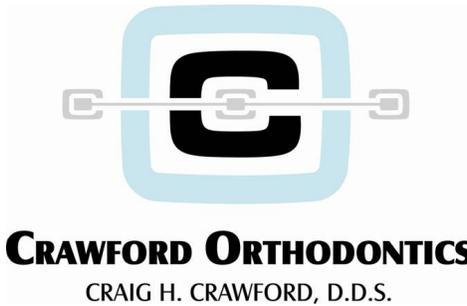
\* \_\_\_\_\_  
(responsible party signature)

### Consent for use of photos (optional)

I give my consent to allow my (or my child's) photos for use by Dr. Crawford's Orthodontic office. These photos may be published on our website, Facebook or other social media.

Patient or Parent's name \_\_\_\_\_ Patient or Parent's Signature \_\_\_\_\_

Child's name \_\_\_\_\_ Child's Signature \_\_\_\_\_



*Insurance Policy*

Dear Patients:

Our office will help you maximize your orthodontic insurance benefits. We want you to understand that generally, orthodontic benefits are received once in a lifetime for each individual and have a set maximum. Therefore, once the maximum has been met either in our office or by another orthodontist you will not receive anymore insurance benefits to cover orthodontic care.

When the patient comes for the first visit, we will call your insurance company to verify coverage. This is not a guarantee of benefits and we encourage you to understand your insurance policy, filing deadlines and also confirm your benefits by reading your policy or speaking with your benefits department.

For those patients who have secondary insurance we will first file the primary insurance. As a courtesy to you we will file the secondary insurance to reimburse the insured. If any benefits are not received it is not our responsibility. We encourage you to speak directly to your insurance company regarding any unpaid benefits.

When Dr. Crawford is considered an “out of network Doctor”, this means that the insurance company may not pay Dr. Crawford directly for the treatment. We are happy to file the insurance and if the benefits are mailed to the insured, contact our office so that you can forward the benefits to us.

Any insurance not received by the end of treatment will become the patient’s responsibility. We encourage you to contact us if your policy has not paid within a reasonable time frame.

We look forward to having you as a patient and will do everything we can to help you receive your benefits.

**I authorize that I have read and understand the above insurance policy.**

**Signature of responsible party** \_\_\_\_\_

**Signature of witness** \_\_\_\_\_

**Date** \_\_\_\_\_

## AAOIC SUPPLEMENTAL HEALTH QUESTIONNAIRE

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff, or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Have you, your child, or others accompanying you to today's appointment or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? Date \_\_\_\_\_

Do you, your child, or others accompanying you to today's appointment or other recent acquaintances have:

•A Fever (defined as above 99.6 degrees) Yes \_\_\_\_\_ No \_\_\_\_\_

•A Cough? Yes \_\_\_\_\_ No \_\_\_\_\_

•Shortness of Breath and/or Trouble Breathing? Yes \_\_\_\_\_ No \_\_\_\_\_

•Persistent Pain, Pressure, or Tightness in the Chest? Yes \_\_\_\_\_ No \_\_\_\_\_

I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's orthodontic appointment.

\_\_\_\_\_  
Patient/Parent's Signature

\_\_\_\_\_  
Date