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

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:** _____

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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 _____

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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