MODERNZEN
ORTHODONTICS

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INSTRUCTIONS

Thank you for scheduling a new patient consultation for an orthodontic evaluation with Dr. Robles. Dr. Robles provides an initial "complimentary" consultation in that your out of pocket fee will be waived. In order for a thorough evaluation to be performed, orthodontic records will need to be taken. The cost for these initial records will be submitted to your dental insurance, and if you decide to start, will be discounted from your orthodontic treatment. However, if you would like a copy of these records* after your initial consultation, there may be a records fee involved. (*photos, panoramic x-ray and cephalometric x-ray). _____ Please set aside 20-30 minutes to fill in the forms below.

TIPS:

- If the question is not applicable, please enter N/A for that answer field.
- Enter a cell phone number (not a landline) and valid email address so that you may receive a courtesy automated reminder before your scheduled date and time.
- Please have a copy of your drivers license and if any, a front and back copy of your dental insurance card to upload at the end of these forms.
- Click "FINISH" toward the top right when you have completed.

(ADULT) DATE:

PATIENT INFORMATION		
Patient's First and Last Name:		Check: Male / Female
Patient's Address:		
Patient's Home Phone:	Birth Date:	
Secondary Phone Contact in case of schedule changes:		
Email Address:		
Patient's General Dentist Name:		
General Dentist Address/Phone:		

RESPONSIBLE PARTY INFORMATION		
How many responsible parties?	Relationship to Patient:	
Name:		Birth Date:
Address:		SSN:
City:	State:	Zip Code:
Phone:	2nd Phone Contact in case of schedule changes:	
2nd Responsible party Name:		Birth Date:
Address:		SSN:
City:	State:	Zip Code:
Phone:	2nd Phone Contact in case of schedule changes:	

INSURANCE INFORMATION		
Subscriber's Name on Card:		Birth Date:
Ins Comp:	ID#	SSN:
Employer Name:		Group No#

_____

Responsible Party Full Name Responsible Party Signature

How did you hear about us?

New Patient Medical History Form

Date: _____

Patient Name: _____ Date of Birth: _____

Responses to Patient Health Questionnaire:

	Y	N		Y	N
• Is patient in good health?			• Excessive bleeding?		
• Heart Problems?			• Herpes?		
• Low blood pressure?			• Malignancies?		
• High blood pressure?			• Thyroid problems?		
• Taking blood pressure meds?			• History of mumps?		
• HIV positive?			• History of measles?		
• Allergies to medication?			• History of rheumatic fever?		
• Allergies to metals?			• Receiving psychiatric care?		
• Allergies to latex or balloons?			• Sinus problems?		
• Asthma?			• History of scarlet fever?		
• Arthritis?			• History of stroke?		
• Epilepsy?			• Radiation treatments?		
• Diabetes?			• Birth control pills?		
• Hepatitis?			• Pregnant?		

Any history of taking antibiotics BEFORE a dental treatment? Y N
(If yes – please explain below)

Any history of thumb, finger, gum chewing, nail biting, tongue sucking or tongue thrust? Y N
(If yes – please explain below)

Any further comments you'd like us to be aware of?
(Please explain Yes answers below)

_____

_____

_____
Patient Signature

Sleep Questionnaire / ADULT / S.T.O.P. B.A.N.G. FORM

Patient Name: _____ Study ID # _____

S.T.O.P. B.A.N.G. Screening *	Y	N
1. DO YOU SNORE LOUDLY		
2. DO YOU OFTEN FEEL TIRED, FATIGUED, OR SLEEPY DURING THE DAYTIME?		
3. DO YOU HAVE OR ARE YOU BEING TREATED FOR HIGH BLOOD PRESSURE?		
4. ARE YOU OBESE. VERY OVERWEIGHT - BMI MORE THAN 35 kg/m2?		
5. NECK CIRCUMFERENCE - IS THIS OVER 16 INCHES?		
6. ARE YOU MALE?		
SCORE: YES = 1 0 - 2 / LOW RISK 3 - 4 / INTERMEDIATE RISK 5 - 8 / HIGH RISK		
* Toronto Western Hospital / ASA / American Sleep Association		

*** DO YOU STILL HAVE YOUR ADENOIDS/TONSILS? YES NO**

SUPPLEMENTAL INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

DATE: _____

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.

If you are experiencing flu-like symptoms or have a temperature or simply not feeling good, please CANCEL your appointment ahead of time either through email or leave a voice message. Please do this within 24 hours to avoid a $50 cancellation fee.

Call us back to reschedule your appointment once you are free of symptoms.

We have the right to ask you to leave the premises immediately if you have these symptoms and ask that you self-quarantine yourself for 14 days. You are advised to seek medical help immediately to test for COVID-19. Once you are symptom free, please call us or email us to request for a new appointment.

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 Signature Date

SUPPLEMENTAL INFORMED CONSENT

Delivery of Orthodontic Services by Teledentistry

When you start orthodontic treatment, you have the option to receive orthodontic services via Teledentistry (virtual appointment) which involves using electronic and digital communications between you as a patient or parent and your orthodontist. In providing Teledentistry services, our practice will follow the rules and regulations of the state dental board(s) in which the doctor is licensed.

THERE ARE RISKS AND LIMITATIONS WITH TELEDENTISTRY FOR ANY DENTAL TREATMENT INCLUDING ORTHODONTICS:

- In-person office visits are preferred for the best orthodontic outcomes. Teledentistry involves risks that an office visit might avoid, and Teledentistry is best used when an office visit is impractical or in between regular office visits. Your orthodontist will use his/her best judgment in determining when Teledentistry is appropriate.

- Teledentistry, as offered by Dr. Robles is only available for patients **requiring observation visits** that do not need any timely adjustments as determined by Dr. Robles. If there is an issue (such as a broken or loose brackets/wires/appliances), before your virtual appointment, then it is highly recommended that you contact our office at **(301) 900 - 8010** or email us immediately at **info@ModernZenOrthodontics.com**, in order for an adjustment to be performed to relieve this issue. You can use that same time/day slot that was scheduled for your virtual appointment to come in, but you still need to let us know if you are coming in.

- When using electronic and digital communication in the provision of care, there is potential for the breach of confidentiality and/or inadvertent access of protected health information by someone other than your orthodontist, as well as a risk that a loss of electronic communication could mean the loss of Teledentistry services.

- The photography or digital imaging you provide to us (through your video camera accessed from either your phone, laptop or computer), can only give a superficial view and may be inadequate to identify all areas of concern. Although we strive to provide excellent service using Teledentistry, treatment or recommendations based solely on Teledentistry may not allow adequate monitoring of unexpected responses to treatment. Teledentistry is not meant to provide a diagnosis or adequate monitoring of other oral conditions. This is conducted through an in-office visit with your General Dentist.

Do you understand the risks and limitations of Teledentistry and hereby consent to forwarding patient-identifiable information to our practice using electronic communications? Yes____ No____

Consent to treatment using Teledentistry? Yes____ No____

Patient Signature: _____ Date: _____

PLEASE SUBMIT THE FOLLOWING:

- A copy of a government issued identification with your photo (ex., drivers license or passport).
- Your insurance card so we can follow up with them regarding any orthodontic benefits you may have.

FULL NAME of Responsible Party

SIGNATURE

PATIENT NAME