Stephen L. Godwin, DMD, DMSc
Practice Limited to Orthodontics

410-838-2244 **610 S. Main Street**
410-893-7493 fax **Bel Air, MD 21014**

Welcome To Our Office

The benefits of a happy, healthy smile are immeasurable! Comfort, function and self esteem are realistic objectives of orthodontic treatment. We hope to exceed your expectations as we pursue that goal. Please fill out these forms completely. The better we communicate, the better we can care for you.

Tell Us About Your Child

Today's Date:____________________ ☐Male ☐Female

Child's Name:______________________________________

Nickname:_____________ Email _____________________

Child's Date of Birth:_____/_____/____Child's Age:_______

Child's Home Phone: ______________________________

Child's Address: ___________________________________

____

School:____

Hobbies/Sports:____________________________________

Does you child play a musical instrument? ☐ Yes ☐ No

If yes, please specify:_______________________________

Who Is Accompanying Your Child Today?

Name:_______________________ Relationship:__________

Do you have legal custody of this child? ☐ Yes ☐ No

List brothers/sisters and ages:_________________________

____

Names of family members seen by us and when they were treated:____

____

Your Child's Dental History

Dentist's Name: ____________________________________

Dentist's Address:___________________________________

____

Dentist's Phone: _________________Last Visit:__________

Have you had or are you currently under orthodontic treatment? ☐ Yes ☐ No If yes, name and address of previous orthodontist: _________________________________

____

Phone: ______________________Last visit:_____________

Mother's Information: ☐ **Stepmother** ☐ **Guardian**

Name: _____________________Birth Date: ____/____/____

Address if different from child:________________________

____

Home Phone: ________________Work: ________________

Email: ____

Employer:____

Job Title: ________________SS#:_____________________

Father's Information: ☐ **Stepfather** ☐ **Guardian**

Name: _____________________Birth Date:____/____/____

Address if different from child:________________________

____

Home Phone:________________ Work:_________________

Email: ____

Employer:____

Job Title: _________________SS#:____________________

Communication:

Is there a court order that limits communication on this patient? ☐ Yes ☐ No If so, please attach a copy of the court order.

How Did You Find Us and Who May We Thank For Referring You To Our Office? (Please mark all boxes that apply.)

☐ My dentist or ☐ hygienist or dental assistant
☐ A family member was treated or is being treated here. Please specify whom:_______________________________
☐ My neighbor, friend, co-worker, teacher or family physician recommended you. Please specify: _____________
____
Saw your advertisement in ☐ Verizon or ☐ Yellow Book
☐ Our website ☐ Other website; please specify ________
☐ Google search ☐ Insurance Directory/Website
☐ School Presentation ☐ Church Bulletin
☐ Local Publication; please specify __________________
☐ Facebook or other social media
☐Other, please explain: ______________________________
____

CONTINUED ON BACK

What Are Your Concerns Regarding Your Child's Smile, Bite and/or Teeth?

____

____

Is your child in good health? ☐ Yes ☐ No If no, please explain: _______________________________

____

Child's physician: ______________________________

Physician's Phone:________________Last visit:__________

Please list all drugs your child is allergic to: _____________

____

Is your child allergic to latex ☐ nickel ☐ ?

Please list all drugs your child is currently taking: __________

____

Has your child had any major changes in his/her health in the past year? ☐ Yes ☐ No
If yes, please specify:

____

Has your child been hospitalized within the past year? If yes, please specify: ☐ Yes ☐ No

____

Does your child need to be premedicated with antibiotics before dental treatment? ☐ Yes ☐ No
If yes, please specify:

____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Does/Did Your Child Have Any Of The Following Habits?

Habit		Habit	
Thumb/finger sucking	Y N	Mouth breathing	Y N
Lip biting/sucking	Y N	Tongue thrust	Y N
Teeth clenching/grinding	Y N	Nail biting	Y N

Has Your Child Ever Had Any Of The Following Medical Problems/Procedures?

Condition		Condition	
Heart problems/murmur	Y N	Heart disease	Y N
Difficulty in breathing	Y N	High blood pressure	Y N
Difficulty in swallowing	Y N	Rheumatic fever	Y N
Difficulty in sleeping	Y N	Hepatitis	Y N
Persistent cough	Y N	Herpes	Y N
Sinus problems	Y N	HIV/AIDS	Y N
Frequent vomiting/nausea	Y N	Syphilis/Gonorrhea	Y N
Recent weight loss	Y N	Thyroid Disease	Y N
Dizziness/Fainting Spells	Y N	Kidney Disease	Y N
Seizures/Epilepsy	Y N	Tumors/Cancer	Y N
Joint Pain	Y N	Radiation Treatment	Y N
Blurred Vision	Y N	Anemia	Y N
Headaches	Y N	Asthma	Y N
Hearing Problems	Y N	History of diabetes	Y N
Emotional Problems	Y N	Skin disorders	Y N
Stomach Problems/Ulcers	Y N	Learning difficulties	Y N
Frequent mouth ulcers	Y N	Speech difficulties	Y N
Allergies	Y N	Chewing difficulties	Y N
Pain in jaw/head/neck	Y N	Neck/jaw/head injury	Y N

Has your child experienced clicking sounds or pain of the jaw joints upon opening/closing of the mouth? ☐ Yes ☐ No

Has your child experienced any other serious medical conditions not list above? ☐ Yes ☐ No If yes, please specify:_______________

____

____

Has your child experienced her first period? ☐ Yes ☐ No
Is your child pregnant? ☐ Yes ☐ No

Thank you for filling out this form completely. It will enable us to help your child more effectively. If you have any questions at any time, please feel free to ask.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical history. I authorize the doctors and staff at Bel Air Orthodontics to perform the necessary dental services associated with my child's orthodontic care.

____
Signature of parent or guardian Date

Relationship to patient_________________________

I understand that I am responsible for payment of services rendered.

____
Signature of parent or guardian Date

To receive updates on current events, contests and exciting news from Bel Air Orthodontics, please provide us with you or your child's email address. ___________________________________ (Your email address will be held in strictest confidence.)

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Dental Insurance Information

Do you have dental insurance? ☐ Yes ☐ No

If you have dental coverage, our staff is happy to assist you in verifying your coverage, filing your claims, and working with you to maximize your insurance reimbursement for covered services. While we are pleased to file dental claims on your behalf, we are not responsible for any limitations in coverage that may be included in your plan.

The following information regarding your coverage is required for filing of claims:

Primary Orthodontic Insurance

Insurance Co. Name:______________________________

Address:______________________________

Phone: ____________ Group #: ____________ Policy #: ____________

Policy Owner's Name: ______________________________ SS#:____________

Relationship to Patient:____________ Policy Holder's DOB:_____/_____/_____

Policy Owner's Address:______________________________ Phone:____________

Employer: ____________ Employer's Address:____________

Effective Date of Coverage: ____________

I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I certify that the information I have provided is true and correct to the best of my knowledge. I understand that it is my responsibility to advise Bel Air Orthodontics of any changes in my insurance coverage or policy information.

____
Signature/Primary Policy Holder Date

Secondary Orthodontic Insurance

Insurance Co. Name:______________________________

Address:______________________________

Phone: ____________ Group #: ____________ Policy #: ____________

Policy Owners Name: ______________________________ SS#:____________

Relationship to Patient:____________ Policy Holder's DOB:_____/_____/_____

Employer: ____________ Employer's Address:____________

Effective Date of Coverage: ____________

I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I certify that the information I have provided is true and correct to the best of my knowledge. I understand that it is my responsibility to advise Bel Air Orthodontics of any changes in my insurance coverage or policy information.

____
Signature/Secondary Policy Holder Date

For Office Use Only

Patient Name:______________________________ Birthdate:____________

Address:______________________________ Phone:____________

Lifetime Maximum:__________ ind. or fam. (circle) Payable @ ______% Used to date:__________ Waiting Period? Y/N, If yes:__________

Ded:__________ Paid yet?__________ Age Restrictions:__________ Who: Employee, Spouse, Dependents (circle)

Disbursement:__________% IP, AUTO or RE-SUBMIT (circle), MONTHLY or QRTLY or SEMI-ANNUALLY or ANNUALLY (circle)

____

Records thru Ortho LTM or Preventative: Pan (CDT code D0330):__________ Ceph (CDT code D0340):__________

Photos (CDT code D0350):__________ Models (CDT code D0470):__________

Staff Name & Date:______________________________ Ins. Rep. Name:____________

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Medical Insurance Information

Do you have medical insurance? ☐ Yes ☐ No

If you have medical coverage, our staff is happy to assist you in verifying your coverage, filing your claims, and working with you to maximize your insurance reimbursement for covered services. While we are pleased to file medical claims on your behalf, we are not responsible for any limitations in coverage that may be included in your plan.

The following information regarding your coverage is required for filing of claims:

Primary Medical Insurance

Insurance Co. Name:____________________

Address:____________________

Phone: ______________ Group #: ______________ Policy #: ______________

Policy Owner's Name: ____________________ SS#:______________

Relationship to Patient:______________ Policy Holder's DOB:_____/_____/_____

Policy Owner's Address:____________________ Phone:______________

Employer: ______________ Employer's Address:______________

Effective Date of Coverage: ______________

I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I certify that the information I have provided is true and correct to the best of my knowledge. I understand that it is my responsibility to advise Bel Air Orthodontics of any changes in my insurance coverage or policy information.

____

Signature/Primary Policy Holder Date

Secondary Medical Insurance

Insurance Co. Name:____________________

Address:____________________

Phone: ______________ Group #: ______________ Policy #: ______________

Policy Owners Name: ____________________ SS#:______________

Relationship to Patient:______________ Policy Holder's DOB:_____/_____/_____

Employer: ______________ Employer's Address:______________

Effective Date of Coverage: ______________

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____

Signature/Secondary Policy Holder Date

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Patient Name:____________________ Birthdate:______________

Address:____________________ Phone:______________

Lifetime Maximum:__________ ind. or fam. (circle) Payable @ ______% Used to date:__________ Waiting Period? Y/N, If yes:__________

Ded:__________ Paid yet?__________ Age Restrictions:______________ Who: Employee, Spouse, Dependents (circle)

Disbursement:__________ % IP, AUTO or RE-SUBMIT (circle), MONTHLY or QRTLY or SEMI-ANNUALLY or ANNUALLY (circle)

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Records thru Ortho LTM or Preventative: Pan (CDT code D0330):__________ Ceph (CDT code D0340):__________

Photos (CDT code D0350):__________ Models (CDT code D0470):__________

Staff Name & Date:____________________ Ins. Rep. Name:______________

CONSENT FOR PUBLICATION OF NAME AND/OR PHOTOGRAPH FOR USE BY BEL AIR ORTHODONTICS

CONTEST WINNER

Patient Giving Consent: Name: ____

Telephone: ___________________ E-mail: ____

To The Patient or Person Authorized to Give Consent:
Bel Air Orthodontics is proud of our patients and their accomplishment and we'd like to spread the news. By signing this form, you will consent to the use and publication of your name and/or photograph on the Bel Air Orthodontics' contest bulletin boards, website, Facebook page and/or local printed publication.

Signature: ____Date:_______________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________________ (Please print)

Relationship to Patient: ____

Personal Representative's Signature: ____

Right to Revoke: You have the right to revoke this Consent at any time by giving Dr. Stephen L. Godwin written notice of your revocation. Please understand that revocation of this Consent will not affect any action Dr. Godwin took prior to receiving your revocation.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Consent for Publication, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)