PATIENT INFORMATION FORM
Galati Orthodontics
Dr. Jay Galati DDS, MSD, PC

(Please print clearly and complete in full)

Date_____

Patient's full name_____

Male_____ Female _____ Date of Birth _____ Age _____ SSN#_____

Cell Phone_____ Home Phone_____ Email _____

Home Address: _____ Unit Number (if applies) _____

City _____ State_____ Zip Code_____

If patient is a minor, name of person(s) with patient at exam appointment_____
School _____ Grade _____

Who may we thank for referring you to our office? _____
Who is the patient's General Dentist? _____
Has Patient seen/treated by another Orthodontist? _____ If yes, When? _____

***Important* Please fill out below in full, for any person who could be at appointment or be a point of contact**

Relationship (circle one): Self/Spouse/Mother/Father/Step-parent/Guardian **Financially Responsible? Y/N**

Name_____ Date of Birth_____

Married ____ Divorced ____ Widow____ Single ____ Remarried ____
Cell phone _____ Home phone _____
Email _____
Home Address _____ Unit Number (if applies) _____
City _____ State _____ Zip Code _____ SSN _____
Employer_____ Occupation_____ Work phone_____

Relationship (circle one): Self/Spouse/Mother/Father/Step-parent/Guardian **Financially Responsible? Y/N**

Name _____ Date of Birth_____

Married ____ Divorced ____ Widow____ Single____ Remarried ____
Cell phone _____ Home phone _____
Email _____
Home Address _____ Unit Number (if applies) _____
City _____ State _____ Zip Code _____ SSN _____
Employer _____ Occupation_____ Work phone_____

DENTAL AND MEDICAL HISTORY
Galati Orthodontics
Dr. Jay Galati DDS, MSD, PC

Patients Name: _____

Family Physician: _____
Is patient under the care of a Physician? _____ If Yes, for what? _____

Are you taking any medications now? Please list: _____
_____

Are you allergic to any medications? Please list: _____

Has the patient been diagnosed or treated for any of the following? (Circle all that apply)

Abnormal Blood Pressure	Diabetes	Lupus
ADD/ADHD	Dizziness/Fainting	Mental Disorders
AIDS/AND OR HIV	Epilepsy	Nervous Disorders
Allergy to Codeine/Penicillin	Excessive Bleeding	Pacemaker
Anemia	Endocrine Problems	Psychiatric Treatment
Artificial heart valve	Glaucoma	Radiation Treatment
Artificial joints	Hay Fever	Rheumatic Fever
Arthritis	Headaches/Earaches/Migraines	Rheumatism
Asthma	Hearing Problems	Sleep Apnea
Blood Clots	Heart Disease	Stroke
Blood Disorder	Heart Murmur	Thyroid Disorder
Blood Disease	Heart Surgery	Tonsils/Adenoids Removed
Blood Transfusion	Hemophilia	Tuberculosis
Bone Disorders	Hepatitis A/B/C	Ulcer
Cancer or Tumor	Herpes Simplex Virus Type 1/2	
Chronic Cough	Kidney/Liver Disorders	
Congenital Heart Defect	Lung Disorders	

Any Trauma to the Head/Neck/Face? _____
Other: _____

Please circle YES or NO to all of the following:

Have you ever had speech therapy? If yes how long/what age? _____	YES NO
Is any part of the patient's mouth sensitive to temperature or pressure? _____	YES NO
Any pre-medications required before dental procedures?	YES NO
Has the patient ever taken medication for their bones?	YES NO
Does the patient have a latex allergy?	YES NO
Does the patient have a metal allergy?	YES NO
Does the patient have a persistent finger/thumb habit?	YES NO
Is the patient a mouth breather (versus primarily breathing through nose)?	YES NO
Does the patient have difficulty breathing through their nose?	YES NO
Does the patient vomit/gag easily?	YES NO
Does the patient grind or clench their teeth?	YES NO
Does the patient experience any popping/locking/pain of the jaw?	YES NO
Has the patient been diagnosed/treated for TMJ disorder?	YES NO
Has the patient ever had periodontal treatment advised?	YES NO
Is the patient a tobacco user? Frequent/Occasional?	YES NO
Is the Patient/Parent aware that appointments may infringe on work/school?	YES NO

Benefits of orthodontics include aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment.

By signing below, I am stating that I have read and fully understand the above. I also recognize that my diagnostic records and my name may be used for educational and promotional purposes. I truthfully answered all of the above questions to the best of my knowledge and agree to inform this office of any changes in my medical, dental, or family history. In addition, I hereby authorize Dr. Jay R. Galati to perform a complete orthodontic evaluation.

_____ _____
Signature of patient, parent or guardian Date

Assignment of Benefits Agreement
Galati Orthodontics
Dr. Jay Galati DDS, MSD, PC

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this form and/or any other necessary assignment documents that may be required by you insurance company. This instructs your insurance company to make payment directly to our office.

- We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide services.

- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 90 days, we ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

- Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for the full amount at that time.

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

- It is your responsibility as the patient/responsible party to notify our office and provide any essential documents in the event your Insurance coverage/company changes and/or terminates during treatment with our office. In the event that your insurance coverage/company changes during treatment and your new insurance plan denies payment coverage of remaining benefits, it is your responsibility to pay the amount in full at that time.

☐ **NO CURRENT DENTAL INSURANCE**

DENTAL INSURANCE INFORMATION (Please fill out in full)

Primary insurance information: Subscriber's Name _____
Social security number_____ Date of Birth_____
Insurance Company_____ Phone Number _____
Place of Employment_____
Insurance Address_____ City_____ State_____ Zip_____
Group Number _____ ID Number _____

Secondary insurance information: Subscriber's Name _____
Social security number_____ Date of Birth_____
Insurance Company_____ Phone Number _____
Place of Employment_____
Insurance Address_____ City_____ State_____ Zip_____
Group Number _____ ID Number _____

WE WILL NEED A COPY OF YOUR CURRENT DENTAL INSURANCE CARD

By signing this I also authorize release of information to my insurance company to assist in payment of my claims.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DRECTLY TO DR. JAY GALATI D.D.S, M.S.D., P.C. THIS AGREEMENT SHALL BE IN FORCE AND EFFECTIVE UNTIL REVOKED BY THE PATIENT OR REPRESENTATIVE SIGNING THIS AGREEMENT. BY SIGNING THIS AGREEMENT, I CONFIRM ALL INFORMATION GIVEN ABOVE IS CORRECT AND COMPLETED IN FULL.

_____ _____ _____
Print Patient Name | Signature of Patient/Responsible Party | Date

Dr. Jay Galati DDS, MSD, PC
Galati Orthodontics
8573 East Princess Drive, Suite 203
Scottsdale, Arizona 85255
(480) 656-7801

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND HIPAA ACKNOWLEDGEMENT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and the uses and disclosures we may make of your protected health information, as well as other important matters regarding your protected health information. A Copy of our Notice is available with this Consent. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices at any time. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Dr. Jay R. Galati** Telephone: **(480) 656-7801**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

Patient Name: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.