

WELCOME TO OUR PRACTICE

Our mission at Wesley Chapel Orthodontics is to treat every patient in a friendly, personal manner and to provide exceptional service. Our goal is to exceed your expectations.

APPOINTMENT SCHEDULE

We understand the time demands on working parents and the attendance requirements of schools. Our schedule is organized to maximize our availability during non-school hours. There are only a few procedures during the course of treatment (generally the longest ones) that we ask that you to be seen during school hours.

Our goal is to see each patient on time and have adequate time to perform each procedure without being rushed. It is important to us that we have time to interact with you and get to know each patient and their family during the course of treatment. Do not hesitate to ask Dr. Seymour any questions you have at any time. We have plenty of seating in the treatment area, parents are always welcome to join us at your child's regular appointments.

We are meticulous about staying on schedule. Please try to be on time for your appointments as we will be ready for you. In fairness to other patients we may be required to reschedule your appointment if you are significantly late.

Please notify the front desk if you cannot make your scheduled appointments. It is much easier to reschedule if we know ahead of time.

COOPERATION

Our goal is for each patient to realize the most beautiful smile possible. A great smile improves self-esteem and adds to the overall quality of life. Your cooperation is essential to achieving this goal. This includes excellent hygiene, wearing elastics (rubber bands) and other auxiliaries, having little or no breakage of the braces, expanders, and aligners, and keeping your regular appointment schedule.

We are fortunate that we are able to provide the highest quality orthodontic care for our patients and improve their appearance, self-esteem, and dental health. We are committed to making your orthodontic treatment a worthwhile and meaningful experience.

Dr. Jeffrey Seymour and Staff

REFERRAL REWARDS PROGRAM

Nothing means more to our practice than the referral of friends and families. It is one of the best ways for us to grow our practice and become a greater part of the Wesley Chapel community.

We greatly appreciate the trust and confidence of a referral and we want to reward you for it!

For each new family or individual that you refer to Wesley Chapel Orthodontics that begins treatment, you will receive \$100 off of your existing balance.

If you do not have a balance, you will receive one of the following:

- \$100 GIFT CERTIFICATE to The Shops at Wiregrass mall
- FREE SET of new or replacement retainers (they do wear out and get lost occasionally!)
- FREE TEETH WHITENING KIT (custom trays and initial supply of whitening gel)

If you refer 5 or more families or individuals you will be eligible for greater rewards.

Ask for details.

Thank you for your continued support.

Dr. Jeffrey Seymour and Staff



Jeffrey Seymour, DMD, MS
 Specialist in Orthodontics
 Invisalign Preferred Provider
www.wesleychapelorthodontics.com

2653 Bruce B. Downs Blvd., #113
 Wesley Chapel, FL 33544
 P (813) 973-0030
 F (813) 973-1785

ORTHODONTIC INSURANCE INFORMATION

The information provided is strictly confidential. Please print legibly.

We will be happy to assist you in determining your orthodontic insurance benefits.
 All information must be completed and signed by the insured party.

Patient's Legal Name: _____ Preferred Name: _____
 Birthdate: _____ Age: _____ Sex: M / F

Primary DENTAL Insurance

Name of Insured: _____ Birthdate: _____
 Home Address: _____ City, State, Zip: _____
 Home Phone: _____ Cell Phone: _____
 SS# of Insured: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____
 Address: _____
 City, State, Zip: _____ Telephone #: _____

Insurance Company: _____ Group #: _____
 Address: _____
 City, State, Zip: _____ Telephone #: _____

I understand that upon my request you will file any charges incurred at your office with my insurance company. I understand there is no guarantee of coverage and I am ultimately responsible for the account.

I hereby authorize release of any information relating to this claim and authorize payment directly to Wesley Chapel Orthodontics.

 Signature of insured party for primary insurances

 Today's date



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NEW PATIENT INFORMATION

The information provided is strictly confidential. Please print legibly.

Patient's Legal Name: _____ Preferred Name: _____
 Today's Date: _____ Birthdate: _____ Age: _____ Sex: M / F
 Address: _____ City, State, Zip: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ Email Address: _____
 Family members or friends currently or previously seen by us: _____
 Brothers/Sisters or Sons/Daughters with names/ages: _____
 Hobbies/Interests: _____ School/Grade: _____
 Previous orthodontic consultation? Yes No If so, when/where? _____
 Previous orthodontic treatment? Yes No If so, when/where? _____
 In your opinion, what is your orthodontic problem? _____
 Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Rel. To Patient: _____ Marital Status: S/M/W/D
 Address: _____ City, State, Zip: _____
 Home Phone: _____ Cell/work #: _____
 Email Address: _____ Birthdate: _____
 Employed By: _____ Occupation: _____ Years: _____
 Spouse's Name: _____ Rel. To Patient: _____
 Home Phone: _____ Cell/work #: _____
 Email Address: _____ Birthdate: _____
 Employed By: _____ Occupation: _____ Years: _____
 Do you have orthodontic insurance coverage? Yes No If yes, please fill out insurance form. Thanks!

DENTAL INFORMATION

Dentist's Name: _____ Does The Patient Receive Regular Checkups? Yes No
 Last Dental Exam: _____ Last Dental X-rays: _____
 Other Dental Specialists: _____
 Have you been satisfied with the past dentistry? Yes No If No, please explain _____

 Does the patient currently have, or have had any of the following? (please check)
 Clenching/Grinding Gum Surgery/Food Traps
 Thumb/Finger Habit Nail Biting
 Periodontal Disease Head/Neck Injury
 Jaw/Joint Pain/Head/Neck Pain Colds Sores
 Is there any other dental information we should know? _____

MEDICAL INFORMATION

Physician's Name: _____ Patient's overall health: Excellent / Good / Poor

Is the patient allergic to anything (drugs/food/pollen): _____

Is the patient currently under medical care? Yes No Where/When? _____

Is the patient currently taking any medications? Yes No Please list: _____

Has the patient ever been hospitalized? Yes No Where/When? _____

Does the patient currently have, or had any of the following? (please check)

- | | |
|--|--|
| <input type="checkbox"/> Adenoid Removed | <input type="checkbox"/> AIDS (HIV) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Auto Accident | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug History |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Major Surgery | <input type="checkbox"/> Nasal/Airway Problems |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Tobacco Usage | <input type="checkbox"/> Tonsils Removed |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tubes in Ears |
| <input type="checkbox"/> Venereal Disease | |

Is there any other medical information we should know?

EMERGENCY INFORMATION

Name: _____ Relationship To Patient: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell/Work Phone #: _____

*Signature (Please sign and date today)

Today's date

Update signature

Update date

www.wesleychapelorthodontics.com

Helpful convenient information is at your fingertips.

By visiting our website you are able to accomplish the following:

- View appointment information
- Print ledger/payment history
- View your Invisalign treatment plan
- Receive email reminders for appointments

Please see the front desk staff and sign up today! They will help you register on the computer located in the reception area. Within 24 hours, you will receive a password and be able to access your account information.

Thank you,

Dr. Jeffrey Seymour and Staff

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