wesley chapel orthodontics

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

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

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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)

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

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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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