Orthodontics

Ralph S. Kurti, D.D.S., MS., P.A.

Member
American Association of
Orthodontists

WELCOME TO OUR OFFICE

We are pleased to welcome you as a new patient to our office . We hope that this information will enable you to become more familiar with our services and answer some questions that you may have.

OFFICE HOURS

Our patient treatment hours are Monday's & Wednesday's in our Franklin office 7:30 am to 5 pm, Tuesday's & Thursday's in our Murphy office 8 am to 5 pm and one Friday a month 8 am to 4 pm. In our Robbinsville office we are there one Friday a month 8 am to 4 pm.

APPOINTMENTS

Patients are seen by appointment only. It is impossible for us to see all of our patients after school, therefore we will do our best to rotate appointments to keep the number of times you have to check out of school to a minimum.

To avoid delays, please call at least 24 hours in advance of your appointment if you have loose or broken brackets. If you are unable to keep an appointment and need to reschedule, please let us know as soon a possible. Rescheduling my result in a less desirable appointment time. Time is set aside each day to see emergency patients.

FINANCIAL ARRANGEMENTS

We want your investment in a lifetime of beautiful smiles to work for you from the very first appointment. A payment plan may be set up on a monthly basis for your convenience. We will sit down with you and develop a customized payment plan that will work comfortable for you.

INSURANCE

If you have orthodontic insurance, we will be happy to do the necessary paperwork in some cases accept assignment to assure that you maximize your full benefit.

PATIENT COOPERATION

Successful treatment is based on patient cooperation with appliances, elastic wear, and good oral hygiene. Broken appliances and missed appointments add time to treatment and interrupt progress. Please see your dentists for regular exams and cleanings. Working together will give us "Something to Smile About."

We welcome your questions at any time and look forward to working with you.

Franklin Office
Physical Address: 250 White Oak St.
Franklin, NC 28734
Mailing Address: PO Box 658
Franklin, NC 28744
Phone (828) 524-7477
Fax (828) 524-848

Murphy Office
Physical Address: 426 Hiwassee St.
Murphy, NC 28906
Mailing Address: PO Box 603
Murphy, NC 28906
Phone (828) 837-5004
Fax (828) 835-3464

Robbinsville Office
Physical Address: 41 Ghormley St.
Robbinsville, NC 28771
Mailing Address: PO Box 603
Murphy, NC 28906
Phone (828) 479-3937

Privacy Practices

Ralph S Kurti DDS MA PA
PO Box 658
Franklin, NC 28744

Office (828) 524-7477
Fax (828) 524-8486

(A) Patient

Name:_____

Address: _____

_____

Chart Number: _____ Telephone: _____ Date of Birth: _____

(B) Acknowledge of Receipt

Signed (Patient or Guardian) _____

Printed Name _____

Relationship to Patient _____ Date _____

(C) Good Faith Effort to Obtain Acknowledgement

Describe effort to obtain_____

_____

_____

Reason (if known) why individual whould not sign _____

_____

I _____ Verify that the above information is correct.

Signed (person attempting to obtain acknowledgment)_____

Print Name _____ Title _____ Date _____

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Franklin, NC 28744-0658
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Patient Info

Patient's Name _____ Preferred Name _____ Age _____ Sex _____

Address _____, City _____, State _____, Zip _____ Email Address _____

Home Phone _____ Cell Phone _____ Birthday _____ Social Security# _____

Whom may we thank for referring you to our office's? _____

Who noticed the orthodontic problem? Patient ☐ Parent ☐ Dentist ☐

Patient's Dentist _____ Physician _____

Last Dental Visit _____ Has dentist removed any teeth? _____

If Patient is a minor please complete this section.

Parent's or guardian's name _____ Is patient adopted? Yes ☐ No ☐

Responsible Party Information

Your Relationship to Patient _____ Insured? Yes ☐ No ☐ Social Security# _____

Name _____ Birthday _____ Marital Status _____

Address _____, City _____, State _____, Zip _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

How long at this address _____ Previous Address (if less than 3 years) _____, City _____, State _____, Zip _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Relationship to Patient _____ Insured? Yes ☐ No ☐ Birthday _____

Name _____ Social Security# _____

Employer _____ Occupation _____ No. Years Employed _____

Work Phone _____ Cell Phone _____

Complete the following section if there are any other persons who could be considered part of the responsible party.

Relationship to Patient _____ Insured? Yes ☐ No ☐ Social Security# _____

Name _____ Birthday _____ Marital Status _____

Address _____, City _____, State _____, Zip _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

How long at this address _____ Previous Address (if less than 3 years) _____, City _____, State _____, Zip _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Relationship to Patient _____ Insured? Yes ☐ No ☐ Birthday _____

Name _____ Social Security# _____

Employer _____ Occupation _____ No. Years Employed _____

Work Phone _____ Cell Phone _____

Emergency Information

Name of nearest relative not living with you _____ Phone _____

Complete address _____

If you have insurance, please give your insurance card to the receptionist at the front desk, so they can make a copy of it.

I understand that credit bureau reports must be obtained and that with out this permission no treatment will be started.

Signature (Parent's signature if minor) _____ Date _____

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Date_____

Patient's Name_____

Date of Birth_____

Questionnaire

Describe orthodontic problem in you own words. _____

_____

What is your main concern regarding this orthodontic problem? Cosmetic ☐ Functional ☐

Describe patients temperament. _____

What is patients hobbies and sports? _____

List in order of importance three things you would like to get out of your orthodontic treatment.

1. _____ 2. _____ 3. _____

TMJ Questions	Yes	No
Do you ever have ringing in your ears?	☐	☐
Do you ever have dizziness?	☐	☐
Do you have earaches?	☐	☐
Do you have headaches?	☐	☐
Do you have Neck, shoulder or back soreness?	☐	☐
Does your jaw ever lock open or closed?	☐	☐
Does your jaw joint ever hurt?	☐	☐

Airway Questions

History of mouth breathing?	☐	☐
Have tonsils and adenoids been removed? When_____	☐	☐
History of ear infections?	☐	☐
History of frequent colds?	☐	☐
History of asthma?	☐	☐
History of allergies?	☐	☐
History of sinus infections? Frequency_____	☐	☐
History of snoring at night?	☐	☐
History of sleep apnea?	☐	☐
Any speech abnormalities?	☐	☐

General Health Questions	Yes	No
(Underline pertinent condition or explain in comments.)		
Does the patient have a health problem now?	☐	☐
History of injury to face, head or teeth?	☐	☐
History of liver or kidney problem, epilepsy, endocrine disorders?	☐	☐
History of heart trouble, rheumatic fever, diabetes, bleeding disorders?	☐	☐
Have had AIDS or Hepatitis B?	☐	☐
Is patient under a doctors care or taking medication?	☐	☐
History of trauma or accidents?	☐	☐
Has patient reached puberty (girls-menstruation, boys voice change)?	☐	☐
Is patient allergic to any medication, latex, or metals? What _____	☐	☐

Does Patient Have Any Of The Following Habits

Finger or thumb sucking?	☐	☐
Teeth grinding?	☐	☐
Clinching?	☐	☐
Nail biting?	☐	☐

Are You Aware That The Success Of Treatment Is Dependent On Patient Cooperation?	☐	☐
Has Patient had previous orthodontic examination?	☐	☐
Do you anticipate a transfer or move in the near future?	☐	☐
Has anyone in the family had orthodontic care?	☐	☐

Comments_____

_____

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Dental Insurance Claim Consent

Chart _____

Policy Holder/Subscriber Information(For Insurance Company)

1. Full Name _____ Date of Birth _____ Gender M ☐ F ☐

Address _____ City _____ State _____ Zip _____

Policyholder/Subscriber(SSN or ID#) _____ Plan/Group Number _____

Employer Name _____

Please fill out the information in box# 2 if there is dual insurance coverage.

Policy Holder/Subscriber Information(For 2nd Insurance Company)

2. Full Name _____ Date of Birth _____ Gender M ☐ F ☐

Address _____ City _____ State _____ Zip _____

Policyholder/Subscriber(SSN or ID#) _____ Plan/Group Number _____

Employer Name _____

Patient Information

3. Relationship to Policyholder/Subscriber in Box#1 Self ☐ Spouse ☐ Dependent Child ☐ Other ☐

If Applicable, Relationship to Policyholder/Subscriber in Box #2 Self ☐ Spouse ☐ Dependent Child ☐ Other ☐

Full Name _____ Date of Birth _____ Gender M ☐ F ☐

Address _____ City _____ State _____ Zip _____

Student Status FTS ☐ PTS ☐

Authorizations

4. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected heath information to carry out payment activities in connection with this claim.

Patient/Guardian Signature _____ Date _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Ralph S. Kurti D.D.S., MS., P.A.

Subscriber Signature for Box#1 _____ Date _____

Subscriber Signature for Box#2 _____ Date _____