# FLORIDA ORTHODONTIC INSTITUTE

*A Professional Association*

Leo Chin, D.M.D., M.S.D., M.S.

| 5020 Gunn Hwy., #200 | 406 N. Plant Ave. | 29438 State Road 54 | 2220 Seven Springs Blvd. | 16735 FishHawk Blvd. |
|---|---|---|---|---|
| Tampa, FL 33624 | Plant City, FL 33563 | Wesley Chapel, FL 33543 | New Port Richey, FL 34655 | Lithia, FL 33547 |
| (813) 264-7006 | (813) 757-0651 | (813) 907-1888 | (727) 376-6166 | (813) 689-6389 |


Dear Patients and Parents,

Welcome to FLORIDA ORTHODONTIC INSTITUTE. Please allow me to introduce myself. In 1987, I graduated from WASHINGTON UNIVERSITY, SCHOOL OF DENTAL MEDICINE in St. Louis with honors and also received several awards upon graduation. After graduation, I completed a Residency in General Dentistry at EMORY UNIVERSITY in Atlanta for one year before I pursued Orthodontic specialty training in Philadelphia. In 1991, I received my Orthodontic Certificate and my Master degrees from TEMPLE UNIVERSITY in Philadelphia. I also received an Award for Clinical Excellence from the Department of Orthodontics, and upon graduation I was appointed to a part-time faculty position in the department. After I left Philadelphia in 1992, I worked for two years as an associate in a busy orthodontic practice in Tallahassee, Florida before I moved to Tampa in 1994.

I founded FLORIDA ORTHODONTIC INSTITUTE in TAMPA in September of 1994. Since September of 1997, I have started my second office in WESLEY CHAPEL. In January 1999, I added the third office in PLANT CITY, the fourth office in NEW PORT RICHEY in January 2001, and the fifth office in RIVERVIEW in May 2011. I moved my Riverview office to FishHawk, LITHIA in February 2013. My philosophy is to provide orthodontic treatment at a reasonable fee so that more people can benefit from the results of orthodontics in the Tampa Bay area.

I am a member of THE AMERICAN DENTAL ASSOCIATION, FLORIDA DENTAL ASSOCIATION, HILLSBOROUGH COUNTY DENTAL ASSOCIATION, and WEST PASCO DENTAL ASSOCIATION. In March 2004, I completed the certification exams and was certified as a Diplomate of the AMERICAN BOARD OF ORTHODONTICS. The American Board of Orthodontics is the only orthodontic specialty board recognized by the American Dental Association and sponsored by the American Association of Orthodontists. Look forward to meeting you.

Sincerely,

Leo Chin, D.M.D., M.S.D., M.S.

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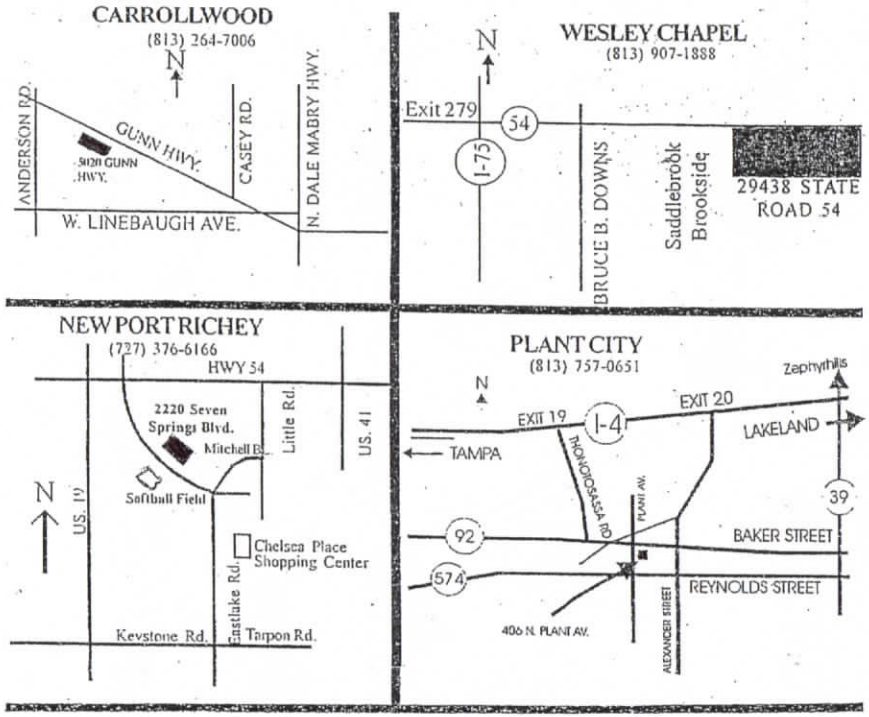
DIPLOMATE
AMERICAN BOARD
OF ORTHODONTICS

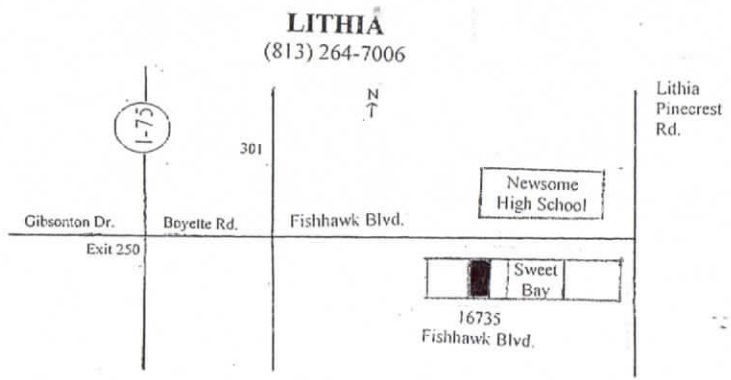
www.floridaorthodontic.com
Fax (813) 264-6072

# WELCOME

Patient's Name _____

Appointment Date _____ Time _____




Rev. 08/12

Please fill out this form and bring it to your consultation appointment

**PATIENT INFORMATION**

Patient's Name _____

Nickname _____ SS# _____

School _____ Grade _____

Hobbies/Interests _____

Birthdate _____ Sex F / M Age _____

Address _____

City _____ State _____ Zip _____

Patient's Home Phone _____ Work Phone _____

Patient Referred By _____

Mother's Name _____ SS# _____

Employed by _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Father's Name _____ SS# _____

Employed by _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Person responsible for account _____

_____

*name/billing address if different from above*

Responsible Party: ☐ Married ☐ Separated ☐ Divorced ☐ Single

Do you have orthodontic insurance coverage? ☐ Yes ☐ No

E-mail address _____

Rev. 01/09

## MEDICAL HISTORY

Patient's Physician _____

Date of last physical examination _____

Patient's health: ☐ Excellent ☐ Good ☐ Poor

Is patient under the physician's care? ☐ Yes ☐ No
If yes, condition _____

Has patient been hospitalized or had a serious illness within the last 5 years? Yes/No
If yes, what was the problem? _____

Is patient currently taking any medication? ☐ Yes ☐ No
If yes, list _____

Is patient allergic to any foods, metals, pollen, medicine such as penicillin , or codeine)?

_____

_____

Does the patient have, or has the patient ever had any of the following?
(Please circle Yes/No)

| | | | |
|---|---|---|---|
| HIV/AIDS | Y/N | Heart valve replacement | Y/N |
| Rheumatic Fever | Y/N | Asthma / Hay fever | Y/N |
| Bleeding disorders | Y/N | Cosmetic surgery | Y/N |
| Tuberculosis | Y/N | High blood pressure | Y/N |
| Cleft lip/palate | Y/N | Diabetes | Y/N |
| Hepatitis | Y/N | Kidney problems | Y/N |
| Epilepsy/seizures | Y/N | Liver problems | Y/N |
| Arthritis/Rheumatism | Y/N | Venereal disease | Y/N |

Other _____

Does patient have any disease, condition or other problems not listed above that you think I should know about? _____

_____

For female patients only: Are you pregnant? ☐ Yes ☐ No

Two people to contact in case of emergency:

Name _____ Phone _____

Name _____ Phone _____

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## DENTAL HISTORY

Patient's dentist _____

Date of last dental examination _____

Date of last dental cleaning by dentist _____

What are the chief concerns of the patient's teeth / bite and / or appearance?

_____

Has patient had previous orthodontic treatment? ☐ Yes ☐ No

If yes, when _____ Doctor's Name _____

Has patient had previous orthodontic consultation? ☐ Yes ☐ No

If yes, when _____ Doctor's Name _____

How does patient feel about wearing braces? _____

Does the patient have, or has the patient ever had any of the following:

(Please circle Yes/No)

| | | | |
|---|---|---|---|
| Head / neck injury | Y/N | Thumb/finger sucking habit | Y/N |
| Jaw joint pain / clicking | Y/N | Nail biting | Y/N |
| Daily Headache / neckache | Y/N | Gum disease | Y/N |
| Clenching / grinding | Y/N | Mouth breathing | Y/N |

Other _____

Any other dental services performed, such as extraction, bonding, crown, implant?

_____

Signature _____ Date _____
Patient/Parent/Guardian

Reviewed by _____
Dentist

Rev. 01/09

# FLORIDA ORTHODONTIC INSTITUTE

## INSURANCE INFORMATION

If you have insurance and would like us to file for a pre-determination of benefits, please fill out this form and the top portion of one of your insurance forms. Please bring both forms to your next appointment. If you are planning for us to accept assignment from your insurance company, please be sure to sign and date the line authorizing to pay benefits to the dentist.

Name of insurance company _____

Address of insurance company _____

City _____ State _____ Zip _____

Phone number _____

Policy number _____

Group number _____

Is this insurance carrier primary _____ / secondary _____ *(please check one)*

Name of the Insured _____

Insured address _____

Phone number _____

Social Security Number _____

Birthdate _____/_____/_____

Employed by _____

Employer's address _____

City _____ State _____ Zip _____

Employer's phone number _____

Patient's Name _____

Address *(If different from insured)* _____

City _____ State _____ Zip _____

Patient's Social Security Number _____

Patient's Birthdate _____/_____/_____

Please bring this form and one of your completed insurance forms to your first visit.

Rev. 01/04

FOR OFFICE USE ONLY

I. Age Limit Before Ortho Insurance Expired: _____ years.

II. Insurance verification

a. Indemnity: Ortho Benefit: $ _____ Lifetime/Yearly
up to _____ % of total fee
Deductible: $ _____ Lifetime/Yearly
Pay _____ Monthly / _____ Quarterly
Automatically _____ / Submit _____

b. HMO: Ortho Benefit: _____ % UCF

c. Cigna: Consult: $ _____
Records: $ _____
Banding: $ _____
24 months Active Treatment: $ _____
After 24 mo. Active Treatment: $ _____
Retainers: $ _____

d. Wait Period: Yes _____ / No _____

e. Fee Schedule: Yes _____ / No _____

III. Pre-determination Required: Yes _____ / No _____
Address to mail Pre-determination form to:
_____
_____
_____
_____

IV. Name of Insurance Agent: _____

Rev. 04/13