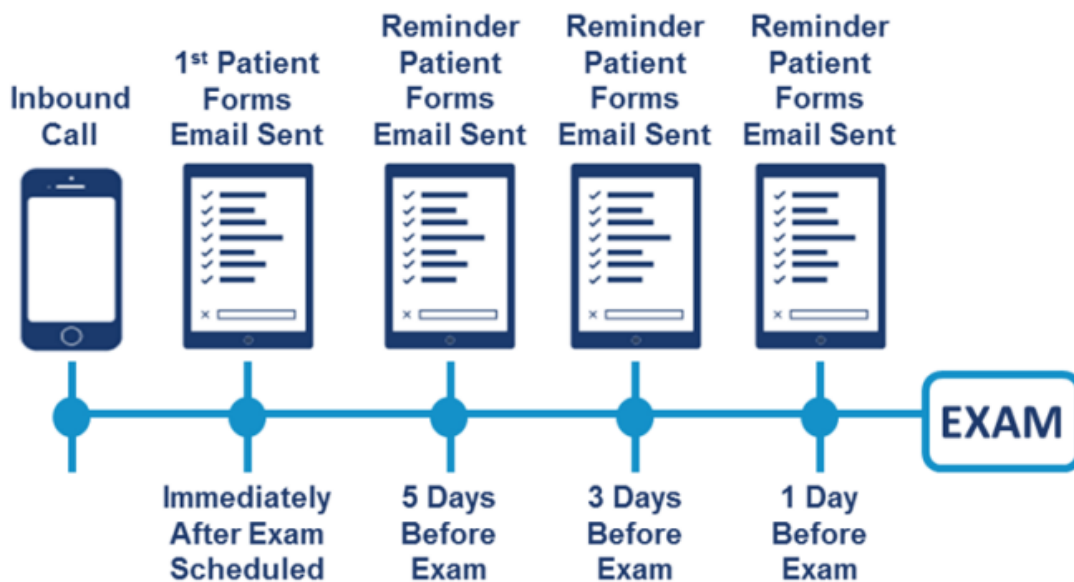


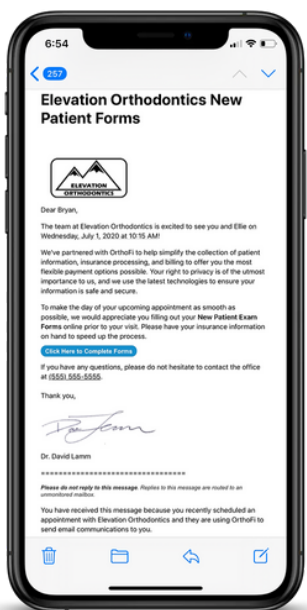
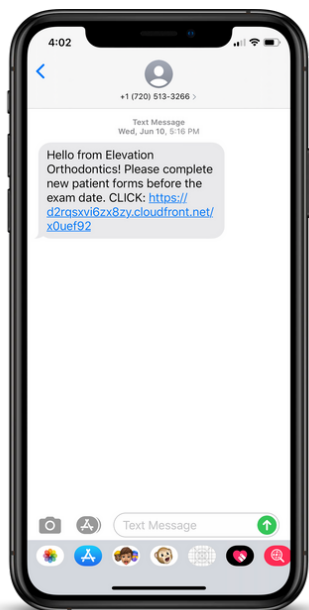
Patient Forms & Email / Text Reminders



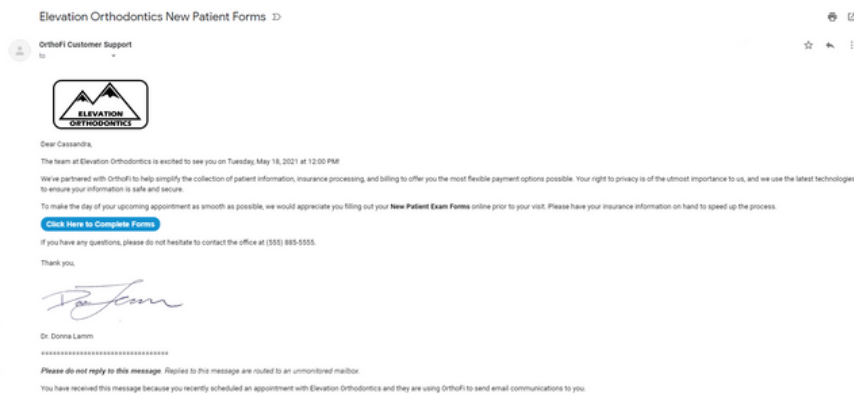
Complete Forms
New Patient Forms Incomplete

Verify Info
Obs Patient Forms Incomplete

- Text reminders sent 14, 7, 4, 2, 1 day(s) prior to scheduled exam
- Welcome email and/or text is auto-sent immediately after adding the patient
- Once the forms are completed, no further reminders are sent from OrthoFi
- Google Translate available for all patients via the globe icon on top right
- Reminders come from a do-not-reply email address and phone number
- Works on any device (smartphone, tablet, PC, Mac)
- Patients can opt-out of texts by replying "stop"
- OrthoFi never shares or sells patient data
- Nothing to download or print



Sample Welcome Emails & Texts



Google Translate Available

Patient Forms Overview

Account Set Up

Your Username

Password*

Confirm Password*

Primary Phone Number*

Security Question*

Please review the **HIPAA Notice of Privacy Practices**

By checking this box, I acknowledge receipt of this notice.*

*Required

CONTINUE Powered by OrthoFi

Patient Information

Patient's Full First Name*

Middle Initial

Patient's Full Last Name*

Name Suffix

Preferred First Name

Date of Birth*

Dental Insurance

Providing your dental insurance before the exam will help us assess your eligibility for benefits.

Do you have Dental Insurance?*

No

Yes

Yes, but I don't know it right now

Who is the Subscriber?*

PATIENT **PARENT** **NEW PERSON**

Patient Medical History: General

Current Dentist*

Most Recent Dental Appointment*

Dental Hygiene (select all that apply)*

Brushes at Least Twice per Day

Flosses Daily

Patient's Gums Bleed

Patient Medical History: Habits

Select all current/past habits that apply to the patient*

Clenching or Grinding Teeth

Lip Sucking / Biting

Mouth Breathing

Nail Biting

Nursing Bottle Habit

Speech Problems and/or Speech Therapy

Patient Medical History: Medications

Is the patient currently taking any medications?*

Yes

No

Is the patient on any form of birth control?*

Yes

No

Is the patient currently taking, or ever taken, a bisphosphonate? This would include any medication used to make bones stronger.*

Yes

No

Financing: Flexible Monthly Payments

Would you like us to qualify you for flexible monthly payments?*

Yes, I'd like flexible monthly payments

No thanks, I plan on paying in full

*Required

CONTINUE Powered by OrthoFi

PREVIOUS PAGE

Financing

A beautiful, healthy smile is an investment in lifelong confidence. Our practice wants to provide everyone the opportunity to afford that perfect smile. That is why we have invested in OrthoFi™, a flexible financing tool that makes paying for high-quality orthodontics care possible.

Who is financially responsible for treatment?*

PRIMARY DENTAL **NEW PERSON**

*Required

CONTINUE

Additional Information

We would love to know about what's important to you while selecting treatment.

Please rate the following on a scale of 1 (not important) to 5 (very important).

Length of Treatment

Comfort During Treatment

Treatment Using Latest Technology

Having a Low Monthly Payment

Quality of Treatment

Starting Treatment Within the Next Month

Is there anything else that we missed that you would like for us to know?*

*Required

CONTINUE Powered by OrthoFi

PREVIOUS PAGE

Thank You!

Your forms are now complete.

Please return this device to the front desk in order to continue to the next steps in your exam.

SIGN OUT