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I acknowledge I have received a copy of this office's  
Notice of Privacy Practices

Today's Date \_\_\_\_\_  
# \_\_\_\_\_

\_\_\_\_\_  
(patient signature) (date)

### PATIENT REGISTRATION

Patient's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
City State Zip

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Sex (Circle): M F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Spouse (optional): \_\_\_\_\_

Main Concern: \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

Have you seen another orthodontist? (circle) YES NO If yes, name \_\_\_\_\_

Have you or any family member been to our office before regarding orthodontics? (circle) YES NO  
If yes, who? \_\_\_\_\_

Family Dentist: \_\_\_\_\_ City \_\_\_\_\_ Date of last dental check-up \_\_\_\_\_

Person(s) responsible for this account: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Orthodontic insurance (circle) YES NO If yes, company \_\_\_\_\_

Medical insurance (circle) YES NO If yes, company \_\_\_\_\_

FOR INSURANCE PURPOSES: Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_

### MEDICAL/DENTAL HISTORY

Family Physician \_\_\_\_\_ Date of last physical \_\_\_\_\_ General Health \_\_\_\_\_

Is patient under a physician's care? (Circle) YES NO If yes, for what? \_\_\_\_\_

List any medications now being taken: \_\_\_\_\_ For what reason? \_\_\_\_\_

List any allergies, drug or latex sensitivity: \_\_\_\_\_

Have tonsils and adenoids been removed? (Circle) YES NO Is patient a mouth-breather? (Circle) YES NO

Does patient vomit, gag, or faint easily? (Circle) YES NO Explain \_\_\_\_\_

Has patient been diagnosed or treated for any of the following, indicate by circling appropriately:

Rheumatic Fever	YES NO	Blood Disorders	YES NO	Lung Disorders	YES NO	Bone Disorders	YES NO
Heart Disease	YES NO	Anemia	YES NO	Asthma	YES NO	Arthritis	YES NO
Abnormal Blood Pressure	YES NO	Hepatitis	YES NO	Diabetes	YES NO	Other	YES NO
Heart Murmur	YES NO	AIDS/HIV Pos.	YES NO	Seizures	YES NO	Explain	_____

**Does Patient require Antibiotic Pre-Medications? YES NO Explain** \_\_\_\_\_

Does the patient experience headaches or neckaches, especially under stress? YES SOMETIMES NO

Does the patient grind or clench teeth? YES SOMETIMES NO

Has the patient had any jaw or head injuries? YES NO

Does the patient experience any clicking, popping or pain while chewing or yawning? YES SOMETIMES NO

Has the patient experienced any episodes of jaws locking in the open or closed position? YES SOMETIMES NO

Has the patient ever consulted anyone regarding a jaw problem? YES NO

Have any teeth been injured due to an accident or fall? YES NO

Does the patient have a persistent thumb or finger habit? YES NO

**Is there any reason the patient may have problems with orthodontic treatment? YES NO**

**Is the patient aware that appointments will infringe on work time, etc.? YES NO**

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

#### FOR OFFICE USE ONLY

Referral acknowledgement communication sent: By \_\_\_\_\_

Records Date: \_\_\_\_\_ To Dr. \_\_\_\_\_ Date: \_\_\_\_\_

To Patient: \_\_\_\_\_ Date: \_\_\_\_\_

## PRIVACY NOTICE

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address.

Thank you