STRAIGHTSET ORTHODONTICS

Patient Information

Today's Date _____

Patient's Name _____ Nick name _____

Address _____ City _____ Zip _____

Email Address_____ Home Phone _____Cell Phone _____

SSN _____ DOB _____/_____/_____ Age _____ Sex _____

School _____ Grade _____ Hobbies/Interests _____

General/Pediatric Dentist _____ City_____Last Visit _____

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

Siblings: Name/Age _____

Responsible Party Information

Father's Name _____ ❑ Biological ❑ Other _____

Address _____ City_____ How Long? _____

Home Phone _____Work Phone _____Cell Phone _____

Social Security Number _____ - ____ - _____ DOB _____/_____/_____ Email _____

Employer _____Occupation _____ How Long? _____

Mother's Name_____❑ Biological ❑ Other _____

Address _____City_____ How Long? _____

Home Phone _____Work Phone_____ Cell Phone _____

Social Security Number _____ - ____ - _____ DOB _____/_____/____ Email _____

Employer _____Occupation _____ How Long? _____

Person financially responsible for this account _____

Orthodontic Insurance Information

Primary Dental Insurance Orthodontic Coverage ❑ Yes ❑ No

Insured's Name _____ Relation _____ Employer _____

DOB _____/_____/_____ SSN _____

Insurance Company _____ Group No. _____ Insurance IDN _____

Insurance Company Address _____ City _____ Zip _____

Do you have dual coverage? ❑ Yes ☐ No

Secondary Dental Insurance Orthodontic Coverage ☐ Yes ❑ No

Name _____ Relation: _____ Employer: _____

DOB _____/_____/_____ SSN _____

Insurance Company _____ Group No. _____ Insurance IDN _____

Insurance Company Address _____ City _____ Zip _____

Insurance Company Phone _____

Emergency Information

Contact Person _____ Relation _____ Phone _____

Medical History

Physician's Name_____ Last Visit _____ Phone Number _____

Current physical condition ❑ Good ❑ Fair ❑ Poor Currently under the care of a physician? ❑ Yes ❑ No

Ever been under the care of a physician for a major illness? ❑ Yes ❑ No _____

Please answer all questions by checking 'Yes' or 'No".

Good Health	❑ Yes ❑ No	Bleeding disorder	❑ Yes ❑ No
Recent illness	❑ Yes ❑ No	Prolonged bleeding	❑ Yes ❑ No
Recent cold, cough	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No
Heart or chest pain	❑ Yes ❑ No	Sickle cell anemia	❑ Yes ❑ No
Heart murmur	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
High blood pressure	❑ Yes ❑ No	Joint replacement	❑ Yes ❑ No
Rheumatic fever	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Kidney disease	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Lung disease	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Hay fever, seasonal allergies	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No	Nasal obstruction	❑ Yes ❑ No
Herpes (cold sores)	❑ Yes ❑ No	Severe headaches	❑ Yes ❑ No
AIDS or HIV positive	❑ Yes ❑ No	Bone disorder	❑ Yes ❑ No
Endocrine disorder	❑ Yes ❑ No	Epilepsy	❑ Yes ❑No
Growth disorder	❑ Yes ❑ No	Canker Sores	❑ Yes ❑ No
Tonsils/Adenoids removed	❑ Yes ❑ No	Antibiotics required for	
Still Growing	❑ Yes ❑ No	Dental appointments	❑ Yes ❑ No

List any drugs (prescription and over the counter) that currently taking and please give reason _____ _____ _____

List any allergies or sensitivities Including drug, latex metal or other _____ _____

Has patient reached puberty? ❑ Girl – Started Menstruation ❑ Yes ❑ No _____

❑ Boy – Voice Changed/Facial hair ❑ Yes ❑ No _____

Dental History

What is the main concern you would like orthodontics to accomplish? _____ _____

Current Dental Health ❑ Good ❑ Fair ❑ Poor
Has an orthodontist been consulted previously? ❑ Yes ❑ No Have you ever been treated with orthodontics before? ❑ Yes ❑ No If yes, please explain: _____
Family history of orthodontic treatment ❑ Yes ❑ No_____
Has the patient ever sucked a thumb or finger? ❑ Yes ❑ No If yes, until what age? ____
Has your child ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No
Does your child have a tongue thrust? ❑ Yes ❑ No Any history of speech problems? ❑ Yes ❑ No
Has your child ever had injuries to your face, mouth, teeth or chin? ❑ Yes ❑ No
Does your child generally breath through their mouth? Awake: ❑ Yes ❑ No Asleep ❑ Yes ❑ No
Does your child have any missing or extra permanent teeth? ❑ Yes ❑ No _____

I have read and understand the above questions. I will not hold Dr. Newman or and member of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature_____**Date** _____

Patient HIPAA Awareness

This notice describes how protected health information about you or your child may be used and disclosed to carry out treatment, payment and healthcare operations and how you can get access to this information. Please review it carefully.

Uses and disclosures of health information

We use and disclose health information about you for treatment, payment and healthcare operations. Your protected health information (i.e., individually identifiable information, such as medical and dental histories, 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:

- Treatment- To other health care providers (i.e., your physician, general dentist, oral surgeon, periodontist, etc.) in connection with our rendering orthodontic treatment to you.
- Payment-To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment for services we provide to you.
- Healthcare Operations-To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontists, 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.
- We may contact you to provide appointment reminders (such as email, voicemail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- The office is engaged in clinical research projects with the overall intent of continually improving the quality of orthodontic care rendered. Permission is granted to utilize orthodontic records for teaching and scientific publications.
- There are additional situations when we are required to use or disclose your protected health information without your consent or authorization (i.e. reporting to law enforcement officials, government agencies, Judicial and Administrative Proceedings, for public health activities, workers compensations, or to avoid a serious threat to health or safety.

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.

Patient rights - *Under the new privacy rules, you have the right to:*

- Request restrictions (in writing) on the use and disclosure of your protected health information.
- Request confidential communication of your protected health information.
- Inspect and obtain copies of your 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 for purposes other than treatment, payment, healthcare operations and other activities, for the last 6 years, but not before April 14, 2003.
- You may, without the 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 of Health and Human Services (which must be filed within 180 days of the violation).

Our legal duty - *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
- 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 protected health information;
- Amend your protected health information if, for example, it is accurate and complete.
- 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 on the acknowledgement of receipt of this notice. If you have any questions about the information in this notice, please ask for our Privacy Contact Person or contact Dr. Newman at our office address. Thank you.

Patient's Name *Date*

Signature of Patient

Signature of Parent or Legal Guardian if the patient is a minor

Print Name of Parent or Legal Guardian