Cullman ORTHODONTICS

Date _____

NEW PATIENT INFORMATION FOR REGISTRATION AND HEALTH HISTORY

Patient's name

_____

Last First Middle

Nickname(s) _____ Date of Birth _____ Age _____ M/ F

Address

_____

Street City State Zip

School _____ Sports/Hobbies _____

Family Members Who Are Patients _____

How did you hear about our office? _____

Dentist Name _____ Date of Last Visit _____.

Chief Oral Concern _____.

Has patient had previous orthodontic treatment? If yes, when and where?_____.

_____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to patient _____

Home Address _____

Home phone _____ Work phone _____ Mobile phone _____

Email _____ Social Security #_____ Date of Birth _____

Employer_____

Occupation _____

Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Spouse's Name _____ Relationship to patient _____

Employer_____

Occupation_____

Social Security #_____ Date of Birth_____ Mobile phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company_____

Group No._____ Member ID. _____

Insurance Co. Address_____

Phone No. _____ Do you have dual coverage? Yes_____ No_____

If yes: Insured's Name_____ Insured's Social Security # _____

Insurance Company_____

Group No._____ Member ID. _____

Insurance Co. Address_____

Phone No._____

MEDICAL HISTORY

Physician's Name_____ Date of Last Exam_____.

Is the patient under the care of a physician? ___Yes ___No If yes, please explain _____.

_____

_____

Please check any of the following that applies to the patient:

- Allergies to drugs
- Allergies to latex
- Malignancies
- Radiation treatments
- Heart ailments
- High blood pressure
- Stroke
- Diabetes – Type?
- Cancer
- Kidney problems
- Venereal disease
- Sinus infection
- Pregnancy

  If yes, what month?
- Liver problems/ Hepatitis
- Tuberculosis
- Asthma
- Psychiatric care/ Emotional disorder
- Excessive bleeding
- Tonsillitis
- Arthritis
- Eye disorder
- Ulcer/ Colitis
- Neurological disorder
- Thyroid problems
- Unusual sounds in the ear while eating
- Severe blow to the mouth or teeth
- Frequent blisters on lips or in the mouth
- Complications from dental extractions
- Clinching or Grinding
- Food impaction
- Teeth sensitive to cold, heat, sweets, pressure
- Bleeding gums
- Mouth breathing
- Oral habits, fingernail biting, thumb sucking etc.
- Tobacco/ Vape use
- Pain around the ear

Please list all medications, if any: _____

_____

If the patient is a minor, please fill out the following growth information:

Girls

- Has the patient started her monthly cycle? _____Yes _____ No If yes, what age? _____
- Has the patient had other signs of pubertal development? _____Yes _____ No

Boys

- Has patients' voice changed? _____Yes _____ No If yes, what age? _____
- Has the patient had other signs of pubertal development? _____Yes _____ No

Self, Parent, or Legal Guardian Signature:_____ **Date:** _____

By signing this document, you will be responsible for the patient's account and if the account is past due and turned over to a collection agency, you agree to pay all additional costs.

Cullman ORTHODONTICS

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your protected health information (i.e., individually identifiable information, such as name, dates, phone/fax numbers, email addresses, home address, social security number, 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 payers 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)
- 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.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Printed Name of Patient/Guardian | Signature | Date