

**PATIENT INFORMATION**

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female

Email \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

I am  Single  Married  Widowed  Separated  Divorced

Other family members seen by us \_\_\_\_\_ Their relation to you? \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US? Please check all that apply**

Dentist  Friend  Relative  Website  Facebook  Newspaper  Internet Search

Who may we thank for referring you to our office? \_\_\_\_\_

**ADDITIONAL RESPONSIBLE PARTY INFORMATION (if other than patient)**

Name of Person Responsible for Account \_\_\_\_\_ Relationship \_\_\_\_\_

Address *if different* than patient \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**Primary** Policy Holder's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union Local# \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Do you have dual coverage?  Yes  No (If yes, please fill out Secondary Policy information below)

**Secondary** Policy Holder's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union Local# \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

**EMERGENCY CONTACT**

Who should we notify in case of emergency? \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## HIPPA PRIVACY NOTICE

**PATIENT NAME:** \_\_\_\_\_

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 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 use of your privacy right 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, and,
- 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 make available to you, 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 accidentally 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.

**PATIENT ACKNOWLEDGEMENT: I hereby acknowledge that I have received and reviewed a copy of the Privacy Notice.**

\_\_\_\_\_  
**Patient or Responsible Party**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**

## MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Physician \_\_\_\_\_ Phone Number \_\_\_\_\_ Date of last visit \_\_\_\_\_

### MEDICATIONS [ ] Not currently taking any medications

Please list current medications including over the counter products \_\_\_\_\_

### ALLERGIES [ ] No History of Allergies

Please check if you are allergic to any of the following: [ ] Dental Anesthetics [ ] Latex [ ] Seasonal

Allergies [ ] Metal Allergy \_\_\_\_\_ [ ] Antibiotics, please list \_\_\_\_\_

[ ] Medications, please list \_\_\_\_\_ [ ] Other \_\_\_\_\_

### PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS:

#### [ ] No Medical Issues or History of Medical Issues

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Anemia/Blood Disorder    | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Asthma/Hay Fever    | <input type="checkbox"/> Autism                   | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Cold Sores/Blisters | <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Depression              | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Excessive bleeding       | <input type="checkbox"/> Fainting spells         | <input type="checkbox"/> Frequent Colds         |
| <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Hepatitis/Jaundice     |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Hives/Skin Rash         | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Osteopenia              | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Persistent cough    | <input type="checkbox"/> Psychiatric Treatment    | <input type="checkbox"/> Seizures                | <input type="checkbox"/> Sinus Problems         |
| <input type="checkbox"/> Stomach ulcers      | <input type="checkbox"/> Thyroid Issues           | <input type="checkbox"/> Tonsil/Adenoid Concerns | <input type="checkbox"/> Tuberculosis           |
- Other medical condition(s) we have not discussed that you feel we should be aware of \_\_\_\_\_

History of or currently on bisphosphonate drugs (Fosamax, Boniva, Reclast, etc. used to treat osteoporosis or multiple myeloma)? \_\_\_\_\_

History of Major Operations? Please Explain \_\_\_\_\_

History of Major Illness? Please Explain \_\_\_\_\_

Involved in a serious accident? Please explain \_\_\_\_\_

Yes No Do you Smoke? If Yes, how much \_\_\_\_\_

### JAW ISSUES/CONCERNS [ ] No TMJ Concerns

Yes No Have you ever had pain or tenderness in your jaw joint (TMJ)? \_\_\_\_\_

Yes No Do your teeth or jaws ever feel uncomfortable when you wake in the morning? \_\_\_\_\_

Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_

Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_

Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_

Yes No Do you experience "tension" headaches? \_\_\_\_\_

Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_

Yes No Do you currently wear a nightguard? \_\_\_\_\_

### FOR WOMEN:

Are you pregnant? Yes No If yes, Week# \_\_\_\_\_ Due Date \_\_\_\_\_

## DENTAL HISTORY

Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_ Date of last visit \_\_\_\_\_

What are the main goals you would like orthodontics to accomplish? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes No Have you ever been told by your physician to take medication before dental treatments? \_\_\_\_\_

Yes No Are you presently in dental pain? \_\_\_\_\_

Yes No Have you ever experienced an unfavorable reaction to dentistry? \_\_\_\_\_

Yes No Are you aware of any missing, extra or impacted teeth? \_\_\_\_\_

Yes No Have your adenoids or tonsils been removed? \_\_\_\_\_

Yes No Have you ever chipped any teeth? \_\_\_\_\_

Yes No Have you experienced injuries to face, mouth or teeth? \_\_\_\_\_

Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_

Yes No Do your gums bleed when you brush? \_\_\_\_\_

### HABITS

Please check if you have or had any of the following habits:

Lip sucking/biting     Thumb Sucking     Finger Sucking     Tongue Thrust     Mouth Breather

Speech Issues     Nail Biting     Other \_\_\_\_\_

### ORTHODONTIC HISTORY

Yes No Have you been evaluated for orthodontic treatment? If yes, who and when \_\_\_\_\_

Yes No Have you ever had orthodontic treatment? If yes, who and when \_\_\_\_\_

Yes No Are you interested in Invisalign? \_\_\_\_\_

### AUTHORIZATIONS (Signature Required)

I understand that the information that I have provided is correct to the best of my knowledge.

I understand that it's my responsibility to inform this office of any changes in my medical, dental, or insurance status.

I authorize North Shore Pediatric Dental and Orthodontics/ Audra B. Reynoso, DMD to use this signature as authorization for all my insurance claims submissions. I authorize release of information to all my insurance carriers.

I authorize payment to be made directly to North Shore Pediatric Dental and Orthodontics/ Audra B. Reynoso, DMD (Assignment of Benefits). I permit a copy of this authorization to be used in place of an original claim form.

I understand that North Shore Pediatric Dental and Orthodontics/ Audra B. Reynoso, DMD bills my insurance carrier as a courtesy and that I am financially responsible for all charges whether or not paid by insurance.

I authorize North Shore Pediatric Dental and Orthodontics/ Audra B. Reynoso, DMD to take diagnostic records, including x-rays, before, during, and following orthodontic treatment.

\_\_\_\_\_

Authorized Signature of Patient/Parent/Guardian

Date

### FOR OFFICE USE ONLY –

Medical and Dental History Reviewed by Dr. Audra B. Reynoso: \_\_\_\_\_

(Drs. Initials)

(Date)