NORTH SHORE
PEDIATRIC DENTAL
& ORTHODONTICS

DR. AUDRA B. REYNOSO
900 CUMMINGS CENTER, STE 119-W
BEVERLY, MA 01915
PHONE: 978-969-6997
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PATIENT INFORMATION

Date: _____

Last Name _____ First Name _____ Middle _____

Nickname: _____ Birth Date ____/____/____ Gender: □ Male □ Female

Address _____

(Street) (City) (State) (Zip)

School _____ Grade _____ Hobbies/Sports _____

Home Phone _____ Cell Phone _____ Email _____

Siblings (Name and Age) _____

Other family members seen by us _____ Relationship to Patient _____

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

□ Dentist □ Friend □ Relative □ Website □ Facebook □ Newspaper □ Internet Search

RESPONSIBLE PARTY INFORMATION

Who is responsible for the account? _____

Parents' Marital Status: □ Single □ Married □ Partnered □ Widowed □ Divorced □ Separated

□ **Mother** □ **Father** □ **Stepmother** □ **Stepfather** □ **Guardian** □ **Other** _____

RESPONSIBLE PARTY FULL NAME: _____ **Date of Birth** _____

Address *if different* than patient _____

Home Phone _____ Cell Phone _____ Work Phone: _____

Email _____ Social Security # _____

Employer _____ Occupation _____ # Years Employed _____

If the above responsible party has Dental Insurance Coverage for the Child, please fill out below:

Insurance Company Name: _____ Insurance Phone # _____

Insurance Address: _____

Insurance Member ID# _____ Group # _____

□ **Mother** □ **Father** □ **Stepmother** □ **Stepfather** □ **Guardian** □ **Other** _____

RESPONSIBLE PARTY FULL NAME: _____ **Date of Birth** _____

Address *if different* than patient _____

Home Phone _____ Cell Phone _____ Work Phone: _____

Email _____ Social Security # _____

Employer _____ Occupation _____ # Years Employed _____

If the above responsible party has Dental Insurance Coverage for the Child, please fill out below:

Insurance Company Name: _____ Insurance Phone # _____

Insurance Address: _____

Insurance Member ID# _____ Group # _____

Other adults we should know about that may bring your child to appointments: Phone Number _____

Last Name _____ First Name _____ Relationship: _____

Are we allowed to share appointment, treatment, and financial information with this person? □ Yes □ No

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

☐ ADD/ADHD	☐ Anemia/Blood Disorder	☐ Anxiety	☐ Arthritis
☐ Asthma/Hay Fever	☐ Autism	☐ Cancer	☐ Cardiovascular Disease
☐ Cold Sores/Blisters	☐ Congenital heart lesions	☐ Depression	☐ Diabetes
☐ Epilepsy	☐ Excessive bleeding	☐ Fainting spells	☐ Frequent Colds
☐ Frequent Infections	☐ Headaches	☐ Heart Problems	☐ Hepatitis/Jaundice
☐ High Blood Pressure	☐ HIV/AIDS	☐ Hives/Skin Rash	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Osteopenia	☐ Osteoporosis
☐ Persistent cough	☐ Psychiatric Treatment	☐ Seizures	☐ Sinus Problems
☐ Stomach ulcers	☐ Thyroid Issues	☐ Tonsil/Adenoid Concerns	☐ 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?_____

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)