Welcome to Hollevoet Orthodontics

1. ABOUT YOU

Today's Date:_____

Name:_____
Last First M. Ini.

I prefer to be called:_____ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age:_____

Home Address:_____

_____
City State Zip

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Email:_____

Hm#:_____ Cell#:_____

Wk#:_____ Ext:_____

Employer:_____

Where & when are best times to reach you?_____

_____

Whom may we Thank for referring you?_____

_____

Other family members seen by us?_____

General Dentist:_____

Last Visit Date:_____

Any Treatment Rendered?_____

2. SPOUSE INFORMATION

His/Her Name:_____

Employer:_____

Wk#:_____Cell#:_____

Birthdate:_____/_____/_____ Age:_____

3. ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name:_____

_____

Insurance Co. Address:_____

_____

City State Zip

Insurance Co. Phone#: ( )_____

Group #:_____

Policy # or Policy Owner's SS#:_____

Policy Holder's Name:_____

Policy Holder's Employer:_____

Policy Holder's Birthdate:_____/_____/_____

Relationship to Patient:_____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name:_____

Relation:_____

Wk#:_____ Hm#:_____

Cell#:_____

4. MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Phone #: ( )_____

Your Current physical health is:

❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician?

❑ Yes ❑ No

Please explain:_____

Are you taking any prescription/over the counter drugs?

❑ Yes ❑ No

Please list each one:_____

For women:

Are you pregnant? ❑ Yes ❑ No Week #:_____

5. MEDICAL HISTORY *continued*

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes/Tuberculosis
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizure/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attach/Stroke
Y N Heart Murmur
Y N Heart Surgery/ Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV +/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers/Colitis

Please list any serious medical condition(s) that you have ever had:_____

Are you allergic to any of the following?

Y N Aspirin Y N Dental Anesthetics Y N Penicillin
Y N Codeine Y N Any Metal/Plastic Y N Latex
Y N Tetracycline Y N Erythromycin Y N Other

6. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____
_____
_____

Have you ever been evaluated for orthodontic treatment?
❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work?
❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is:
❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems?
_____

Do you generally breathe through your mouth?
Y N Awake? Y N Asleep?

Do you have any missing or extra permanent teeth?
❑ Yes ❑ No

Thank you for filling out this form completely

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the orthodontic staff to perform any necessary orthodontic services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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; 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 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 you 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 this Privacy Notice.

_____ _____

Patient/Legal Guardian

Hollevoet Orthodontics

Date