# Welcome to Hollevoet Orthodontics

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

## 1 Tell Us About Your Child

Today's Date:_____

Child's Name:_____
Last First M. Ini.

Child's Birthdate: _____ Age _____

Nickname:_____ ❑ Male ❑ Female

School:_____ Grade:_____

Hobbies/Sports:_____

Child's Home#: _____

Child's Home Address:_____

_____
City State Zip

Whom may we Thank for referring you? _____

_____

List brothers/sisters with age:_____

_____

General Dentist:_____

Last Exam Date:_____Any cavities?_____

## 2 Parent's/Guardian's Information

**Mother** ❑ Step Mother ❑ Guardian

Name:_____ DOB:_____

Wk#: _____ Hm#:_____

Cell#:_____

Address:_____

_____
City State Zip

Employer:_____

Email:_____

**Father** ❑ Step Father ❑ Guardian

Name:_____ DOB:_____

Wk#: _____ Hm#:_____

Cell#:_____

Address:_____

_____
City State Zip

Employer:_____

## 3 Primary Dental 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 Owner's Name:_____

Policy Owner's DOB:_____

Relationship to Patient:_____

## 4 Does/Did the Child Have Any of the Following?

Y N Clenching/Grinding Teeth

Y N Lip Sucking/Biting

Y N Mouth Breather

Y N Nail Biting

Y N Nursing Bottle Habits

Y N Speech Problems

Y N Thumb/Finger Sucking

Y N Tongue Thrust

Please Fill Out Page Two of This Form

## 5 WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

_____

_____

_____

Has the child ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played _____

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing or extra permanent teeth? Y N

**Has the child even had any pain / tenderness in his / her jaw joint (TMI/TMD)?** Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician: _____

Phone#: ( )_____

Date of Last Visit:_____

Is child currently under the care of a physician? Y N

Has puberty begun? Y N

Has menstruation begun? (Girls) Y N

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

**Please list all drugs that the child is currently taking:**

_____

_____

_____

**Please list all drugs/things that the child is allergic to:**

_____

_____

_____

## 6 HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

Y N Abnormal Bleeding
Y N Allergies to Any Drugs
Y N Allergic to Latex/Metals
Y N Allergic to Plastics
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV +/ AIDS
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Tuberculosis (TB)

## 7

I understand that the information that I have given is correct to the best of my knowledge, that is will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

I understand by bringing in my child/step-child for the initial visit, I am responsible for payment indenpendent of what a divorce decree may state. Payment/Reimbursement must be made between the divorced parents. We will not intervene.

_____

Signature of parent or guardian 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 Date


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