Welcome To Hollevoet Orthodontics

1. ABOUT YOU

Today's Date:_____

Name:_____ I prefer to be called:_____ Male ❑ Female ❑
First Last MI

Birthdate: _____/_____/_____ ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Home Address:_____
City State Zip

Hm#:_____ Cell#:_____ Wk#:_____ Ext:_____

Email:_____ Employer:_____

Other family members seen by us?_____ Whom may we thank for refering you?_____

General Dentist:_____ Last Visit Date:_____

Any Treatment Rendered?_____

2. SPOUSE INFORMATION

His/Her Name:_____ Employer:_____

Work#:_____ Cell#:_____ Birthdate: _____/_____/_____ Age:_____

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

His/Her Name:_____ Relation:_____

Wk#:_____ Hm#:_____ Cell#:_____

3. PRIMARY DENTAL INSURANCE

(If different then what was originally provided @ beginning of treatment)

Orthodontic Coverage? ❑Yes ❑ No

Insurance Co. Name:_____ Insurance Co. Phone#: ( )_____

Insurance Co. Address:_____
City State Zip

Policy # or Policy Owner's SS#:_____ Group #:_____

Policy Holder's Name:_____ Policy Holder's Employer: _____

Policy Holder's Birthdate: _____/_____/_____ Relationship to Patient:_____

4. MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____ Phone #: _____

Your Current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Are you currently under the care of a physician? ❑ Yes ❑ No

If yes please explain:_____

_____

_____

_____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No

Please list each one:_____

_____

_____

_____

MEDICAL HISTORY CONTINUED

Have you, the patient, ever had any of the following diseases or medical problems? Please check all that apply.

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

Please list any serious medical condition(s) that you have had in the last year:_____

_____

Are you allergic to any of the following?

- ❑ Aspirin
- ❑ Codeine
- ❑ Tetracycline
- ❑ Dental Anesthetics
- ❑ Any Metal/Plastic
- ❑ Erythromycin
- ❑ Penicillin
- ❑ Latex
- ❑ Other

_____

_____

Have you ever had a serious/difficult problem associated with any previous dental work completed in the last year? ❑ Yes ❑ No

Have you experienced pain/discomfort in your jaw joint (TMJ / TMD) in the last year? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin in the last year? ❑ Yes ❑ No

Please Explain:_____

_____

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 where insurance is involved on an account that has not been paid in full.
- 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 this Privacy Notice.

Patient/Legal Guardian

Date

HOLLEVOET
ORTHODONTICS

701-751-1981 • 1165 W. TURNPIKE DR. • BISMARCK, ND 58501 • WWW.HOLLEVOETORTHODONTICS.COM

Release of Information
(HIPAA Release Form)

***Please list ALL current patients below:**

Patient Name(s):_____ **DOB:** ____/____/____

_____ ____/____/____

_____ ____/____/____

_____ ____/____/____

Release of Information

I ,_____ (parent or guardian if patient is a minor), authorize the release of information rendered to me; including the diagnosis, records, account balance, claims information, and appointments. Information may be released to:

(Please include first & last name)

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Parent_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/____

(parent or guardian if patient is a minor)

Employee Initials: _____

HOLLEVOET
ORTHODONTICS

701-751-1981 • 1165 W. Turnpike Dr. • Bismarck, ND 58501 • www.hollevoetorthodontics.com