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:_____ Nickname:_____ ❑ Male ❑ Female
First Last MI

Child's Birthdate: ____/____/____ Age _____ School:_____ Grade:_____

Child's Home#: _____

Child's Home Address:_____
City State Zip

Hobbies/Sports:_____ Musical instruments he/she playes _____

List brothers/sisters with age:_____

Whom may we Thank for referring you? _____

General Dentist:_____ Last Exam Date:_____ Any cavities?_____

2. Parent's/Guardian's Information

Mother ❑ Step Mother ❑ Guardian ❑ Other:_____

Name:_____ DOB:____/____/____

Cell#:_____ Hm#: _____ Wr#:_____

Address:_____
City State Zip

Email:_____ Employer:_____

Father ❑ Step Father ❑ Guardian ❑ Other:_____

Name:_____ DOB:____/____/____

Cell#:_____ Hm#: _____ Wr#:_____

Address:_____
City State Zip

Email:_____ Employer:_____

3. Primary Dental Insurance

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:_____

Please Fill Out Page Two of This Form

4. WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?

_____

_____

5. CHILD'S DENTAL & MEDICAL HISTROTY

Has the child ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

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

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMI/TMD)? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Floss his/her teeth daily? ❑ Yes ❑ No

Does/Did the child have any of the following:

❑ Yes ❑ No Clenching/Grinding Teeth ❑ Yes ❑ No Nursing Bottle Habits ❑ Yes ❑ No Nail Biting

❑ Yes ❑ No Lip Sucking/Biting ❑ Yes ❑ No Speech Problems ❑ Yes ❑ No Tongue Thrust

❑ Yes ❑ No Mouth Breather ❑ Yes ❑ No Thumb/Finger Sucking

Is child currently under the care of a physician? ❑ Yes ❑ No

Child's Physician: _____ Phone#: _____

Date of Last Visit:_____

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

Has he / she every had any of the following medical problems? Please check all that apply:

❑ Abnormal Bleeding ❑ Cancer ❑ Hearing Impairment ❑ HIV +/ AIDS

❑ Allergies to Any Drugs ❑ Congenital Heart Defect ❑ Heart Murmur ❑ Kidney/Liver Problems

❑ Any Hospital Stays ❑ Convulsions/Epilepsy ❑ Hemophilia ❑ Rheumatic/Scarlet Fever

❑ Any Operations ❑ Diabetes ❑ Hepatitis ❑ Tuberculosis (TB)

❑ Asthma ❑ Handicaps/Disabilities

Is the Child allergic to any of the following: ❑ Latex ❑ Any Metal ❑ Any Plastic

❑ Any Drugs, please list:_____

❑ Foods, please list:_____

❑ Othert:_____

Please list all drugs that the child is currently taking:

_____

_____

_____

6.

I understand that the information that I have given is correct to the best of my knowledge, that it is my responsibility to inform this office of any changes in my child's medical status, and that this information will be held in the strictest of confidence. 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 independent of what a divorce decree may state. Payment/Reimbursement must be made between the divorced parents. Hollevoet Orthodontics 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 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: _____

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