

Orthodontic Patient Registration

Patient Name: _____

Address: Street _____ City _____ State _____ Zip _____

Date of Birth: _____ SSN: _____ Phone Number: _____

Email Address: _____

Please list your chief concerns: _____

How Did You Here about Epic Smiles? Tv Radio Referral Web search Facebook Instagram

Other: _____

Dental Insurance Company

Dental Insurance Company Name: _____

Group #: _____ ID#: _____

Insurance Phone Number: _____

Subscriber Name: _____ Date of Birth: _____

Responsible Party Information (Parent or Guardian)

Name: _____

Relationship to Patient: _____

Parent or Guardian Social Security Number: _____

Phone Number: Home Cell _____

Medical History

Sex: Male Female Other _____

DO YOU HAVE OR HAVE YOU EVER HAD

- | | | | |
|---|--|--|--|
| ADHD/ADD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nickel Allergy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Joint Swelling or Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prolonged Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Known missing permanent teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Endocrine Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Known extra permanent teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tongue Thrust problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bone Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Speech Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever taken or are you currently taking Bisphosphonates | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain, popping or locking when opening or closing jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis or Liver Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscle tenderness or stiffness in jaw or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis (TB) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you clench or grind your teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS or HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ringing in the ears | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Medical History (Continued)

DO YOU HAVE OR HAVE YOU EVER HAD

Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spells of dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous treatment of TMJ or jaw problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Use Botox or fillers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wear a mouth guard for sports or other activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Interested in Botox or fillers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) Medications: _____		
Heart Trouble/ Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) Medications: _____		
Artificial Joint(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) What Year: _____		
Tonsils Removed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) What Year: _____		
Are you Pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) # Months: _____		
Seasonal Allergy Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) Describe: _____		
Drug Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) List: _____		
Thumb, finger or lip sucking habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) Until What Age: _____		
Have you had teeth extracted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) What Year: _____		
Previous Orthodontic Evaluation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) What Year: _____		
Previous Orthodontic Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) What Year: _____		
Type: <input type="checkbox"/> Braces	<input type="checkbox"/> Aligners	<input type="checkbox"/> N/A	Other: _____		
Currently under a doctor's care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(if yes) What for? _____		

Printed Name of Person Filling out Form

Date of Birth

Signature

Date

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Epic Smiles Centers, we are required to keep your health information secure and confidential, by law.

Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We will need to release some or all of your health information, when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services in writing:

(200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (<http://www.hhs.gov>) or by email (OCRComplaint@hhs.gov).

You will not be retaliated against for filing a complaint.

Please contact our HIPAA Compliance Officer, David Willens at (248) 482-2768 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

I have received a copy of the Epic Smiles Centers Notice of Privacy Practices

Acknowledgement:

Date