

## PATIENT

Date \_\_\_\_\_

Patient's last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_

Title  Mr.  Mrs.  Ms.  Miss.  Dr.  Other I prefer to be called \_\_\_\_\_

Birth date \_\_\_\_\_ Sex  Male  Female Social Security# \_\_\_\_\_

Marital Status  Single  Married  Separated  Divorced  Widowed

Home address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Email Address(es) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

## CLOSEST RELATIVE

Spouse or closest relatives name(s) \_\_\_\_\_

Title  Mr.  Mrs.  Ms.  Miss.  Dr.  Other Relationship to patient \_\_\_\_\_

Address (If different than patient address) \_\_\_\_\_

Home Phone (If different ) \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

## DENTIST

Patient's Dentist \_\_\_\_\_ Address, City, State \_\_\_\_\_

Last seen \_\_\_\_\_ Reason \_\_\_\_\_ Next appointment \_\_\_\_\_

Other dentists/dental specialists now being seen : Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

## PHYSICIAN

Patient's Physician \_\_\_\_\_ City, State \_\_\_\_\_

Last seen \_\_\_\_\_ Reason \_\_\_\_\_ Next appointment \_\_\_\_\_

Most recent physical exam \_\_\_\_\_

Other physicians/health care providers being seen now :

Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

Name \_\_\_\_\_ City, State \_\_\_\_\_

Reason \_\_\_\_\_

## GENERAL INFORMATION

What concerns you about your teeth? \_\_\_\_\_

Who suggested that you might need orthodontic treatment? \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

Have you had any previous orthodontic treatment? Please describe \_\_\_\_\_

Have any other family members been treated in this office? Please name them  
\_\_\_\_\_

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain.  
\_\_\_\_\_

## FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? \_\_\_\_\_

Address (if different than page 1) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address(es)  
\_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

## DENTAL INSURANCE

Primary policy holder's full name \_\_\_\_\_ Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

Does this policy have orthodontic benefits?  Yes  No  Don't Know

Secondary policy holder's full name \_\_\_\_\_ Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

Employer \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

Does this policy have orthodontic benefits?  Yes  No  Don't Know

## MEDICAL INSURANCE

Policy holder's full name \_\_\_\_\_

Insurance Company \_\_\_\_\_

## MEDICAL HISTORY

**Now or in the past, have you had:**

- Birth defects or hereditary problems?  Yes  No  DK/U
- Bone fractures or major injuries?  Yes  No  DK/U
- Any injuries to face, head, neck?  Yes  No  DK/U
- Arthritis or joint problems?  Yes  No  DK/U
- Endocrine or thyroid problems?  Yes  No  DK/U
- Diabetes or low sugar?  Yes  No  DK/U
- Kidney problems?  Yes  No  DK/U
- Cancer, tumor, radiation treatment or chemotherapy?  Yes  No  DK/U
- Stomach ulcer, hyperacidity, acid reflux?  Yes  No  DK/U
- Immune system problems?  Yes  No  DK/U
- History of osteoporosis?  Yes  No  DK/U
- Gonorrhea, syphilis, herpes, sexually transmitted diseases?  Yes  No  DK/U
- AIDS or HIV positive?  Yes  No  DK/U
- Hepatitis, jaundice, or other liver problems?  Yes  No  DK/U
- Polio, mononucleosis, tuberculosis, pneumonia?  Yes  No  DK/U
- Seizures, fainting spells, neurologic problems?  Yes  No  DK/U
- Mental health disturbance or depression?  Yes  No  DK/U
- Vision, hearing, or speech problems?  Yes  No  DK/U
- History of eating disorder (anorexia, bulimia)?  Yes  No  DK/U
- High or low blood pressure?  Yes  No  DK/U
- Excessive bleeding or bruising, anemia?  Yes  No  DK/U
- Chest pain, shortness of breath, tire easily, swollen ankles?  Yes  No  DK/U
- Heart defects, heart murmur, rheumatic heart disease?  Yes  No  DK/U
- Angina, arteriosclerosis, stroke or heart attack?  Yes  No  DK/U
- Skin disorder (other than common acne)?  Yes  No  DK/U
- Do you cut a well-balanced diet?  Yes  No  DK/U
- Frequent headaches or migraines?  Yes  No  DK/U
- Frequent ear infections, colds, throat infections?  Yes  No  DK/U
- Asthma, sinus problems, hayfever?  Yes  No  DK/U
- Tonsil or adenoid condition?  Yes  No  DK/U
- Do you frequently breathe through your mouth?  Yes  No  DK/U

**Have you had allergies or reactions to any of the following?**

- Local anesthetics (novocaine, lidocaine, xylocaine)  Yes  No  DK/U
- Latex (gloves, balloons)  Yes  No  DK/U

- Aspirin  Yes  No  DK/U
- Metals (jewelry, clothing snaps)  Yes  No  DK/U
- Penicillin  Yes  No  DK/U
- Other antibiotics  Yes  No  DK/U
- Ibuprofen (Motrin. Advil)  Yes  No  DK/U
- Acrylics  Yes  No  DK/U
- Plant pollens  Yes  No  DK/U
- Animals  Yes  No  DK/U
- Foods  Yes  No  DK/U
- Other substances  Yes  No  DK/U \_\_\_\_\_

**DENTAL HISTORY**

**Now or in the past, have you had :**

- Permanent or extra (supernumerary) teeth removed?  Yes  No  DK/U
- Supernumerary (extra) or congenitally missing teeth?  Yes  No  DK/U
- Chipped or injured primary or permanent teeth?  Yes  No  DK/U
- Any sensitive or sore teeth?  Yes  No  DK/U
- Bleeding gums, bad taste or mouth odor?  Yes  No  DK/U
- Jaw fractures, cysts, infections?  Yes  No  DK/U
- Any teeth treated with root canals or pulpotomies?  Yes  No  DK/U
- "Gum boils." frequent canker sores or cold sores?  Yes  No  DK/U
- History of speech problems or speech therapy?  Yes  No  DK/U
- Difficulty breathing through nose?  Yes  No  DK/U
- Food impaction between the teeth?  Yes  No  DK/U
- Mouth breathing habit or snoring at night?  Yes  No  DK/U
- Frequent oral habits (sucking finger, chewing pen, etc)?  Yes  No  DK/U
- Teeth causing irritation to lip, cheek or gums?  Yes  No  DK/U
- Abnormal swallowing (tongue thrust)?  Yes  No  DK/U
- Tooth grinding or clenching?  Yes  No  DK/U
- Clicking, locking in jaw joints?  Yes  No  DK/U
- Soreness in jaw muscles or face muscles?  Yes  No  DK/U
- Ringing in ears, difficulty in chewing or opening jaw?  Yes  No  DK/U
- Have you ever been treated for "TMJ" or "TMD" problems?  Yes  No  DK/U
- Any broken or missing fillings?  Yes  No  DK/U
- Any serious trouble associated with previous dental treatment?  Yes  No  DK/U

Have you ever been diagnosed with gum disease or pyorrhea? Yes No DK/U

Have you ever had an orthodontic consultation or treatment before now? Yes No DK/U

### PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take. Medication\_\_\_\_\_ Taken for \_\_\_\_\_

Medication\_\_\_\_\_ Taken for \_\_\_\_\_

Medication\_\_\_\_\_ Taken for \_\_\_\_\_

Have you ever taken any medications to strengthen your bones? Please describe \_\_\_\_\_

Do you or have you ever had a substance abuse problem? \_\_\_\_\_

Do you chew or smoke tobacco?\_\_\_\_\_

Have you noticed any changes in your face or jaws? \_\_\_\_\_

Any other physical problems? \_\_\_\_\_

How often do you brush?\_\_\_\_\_ How often do you floss?\_\_\_\_\_

Women : Are you pregnant? Yes No Are you trying to become pregnant? Yes No

### FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

\_\_\_\_\_

Bleeding disorders\_\_\_\_\_ Diabetes\_\_\_\_\_

Arthritis\_\_\_\_\_ Severe allergies\_\_\_\_\_

Unusual dental problems\_\_\_\_\_ Jaw size imbalance\_\_\_\_\_

Other family medical conditions? \_\_\_\_\_

### RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature

\_\_\_\_\_

Patient Full Name

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

Date \_\_\_\_\_

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature

\_\_\_\_\_

Patient Full Name

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

Date \_\_\_\_\_

## MEDICAL HISTORY UPDATES OR CHANGES

Changes \_\_\_\_\_

Signature \_\_\_\_\_

\_\_\_\_\_  
Patient Full Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Date \_\_\_\_\_

### Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/13, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

#### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health

information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to :

- Prevent or control disease, injury or disability
- Report child abuse or neglect
- Report reactions to medications or problems with products or devices
- Notify a person of a recall, repair, or replacement of products or devices
- Notify a person who may have been exposed to a disease or condition or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful Intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PH to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose P to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

## **OTHER USES AND DISCLOSURES OF PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or

disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PH for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

## **YOUR HEALTH INFORMATION RIGHTS**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan, has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handed under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**Amendment.** You have the right to request that we amend your health information, Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such, if we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Sima Rafati, DDS, MS

Telephone : 408 2260-1234 Fax: 408 912-2199

Address : 827 Blossom Hill Rd. Ste. # E-2

Email:info@rafati orthodontics.com

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### Acknowledgement of receipt of

### "Notice of Privacy Practices"

**Dr. Sima Rafati**

### "You may refuse to Sign this acknowledgement"

I have received a copy of this office's Notice of Privacy Practices.

Print Name : \_\_\_\_\_

Signature :

\_\_\_\_\_

Patient Full Name	Patient Signature	Date
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Date : \_\_\_\_\_

### For office use only

We attempted to obtain your acknowledgement of receipts for our notice of Privacy Practices, but acknowledgement cannot be obtained because :

1. Individual refused to sign
2. Communications barriers prohibited obtaining the acknowledgement
3. An emergency situation prevented us from obtaining acknowledgement
4. Other (Please specify)\_\_\_\_\_

We would like to welcome you to our office. In an effort to assist you in receiving the greatest benefit from

your orthodontic insurance, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Date \_\_\_\_\_

**PATIENT'S PRIMARY INSURANCE INFORMATION**

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Insured Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Policy or Group No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Telephone (800 No. if available). \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING INFORMATION IF THE PATIENT IS COVERED BY A SECOND INSURANCE POLICY.**

**PATIENT'S SECONDARY INSURANCE INFORMATION**

Insured Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Patient Relationship to the Insured \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Policy or Group No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Telephone (800 No. if available) \_\_\_\_\_

**RELEASE AND ASSIGNMENT**

Patient's Name \_\_\_\_\_

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATIONS RENDERED, TO MY INSURANCE COMPANY OR COMPANIES. THIS RELEASE IS SOLELY FOR THE PURPOSE OF FACILITATING THE BILLING AND REIMBURSEMENT DIRECTLY TO THE DOCTOR, OF INSURANCE BENEFITS UNDER WHICH I AM ENTITLED.

Signature

\_\_\_\_\_  
Patient Full Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Print your Name \_\_\_\_\_

Signature

\_\_\_\_\_  
Patient Full Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Print your Name \_\_\_\_\_