

SAINI ORTHODONTOCS
10776 Hickory Ridge Road
Columbia, MD 21044
"Getting to Know You"

For Patients Over Age 18 Years

Patient's Full Name: _____ Sex: Female Male Birth Date: _____ Age: _____

Patient's Address: _____ City: _____ State: _____

Zip/Postal Code: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Position: _____ Email: _____

Single Married Separated Divorced

Spouse Name: _____

Spouse Employer: _____ Position: _____ Email: _____

Ok to call you at work: Yes No Work Phone: _____

Person responsible for financial account: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____

Zip/Postal Code: _____ Home Phone: _____

Employer: _____ Position: _____ Email: _____

Dental Insurance Company: _____ ID# _____ Group# _____

Primary Holder's Full Name: _____ Birth day: _____

Does this policy have orthodontic benefit? Yes No

2nd Dental Insurance Company: _____ ID# _____ Group# _____

Secondary Holder's Full Name: _____ Birth Day: _____

Does this policy have orthodontic benefit? Yes No

How did you become aware of this office? _____

Previous Orthodontic Experience: Patient Spouse Parents Brother Sister Children

DENTIST

Patient's Dentist: _____ Last Visit to DDS (Months): _____ Last X-Ray (Months): _____

Address: _____ City: _____ State: _____

Zip/Postal Code: _____ Phone: _____ General Oral Health: _____

PHYSICIAN

Patient's Physician: _____ Phone# _____

MEDICAL HISTORY

- Yes No Are you presently under a physician's care? If so, for what: _____
- Yes No Have you ever been hospitalized? If so, for what: _____
- Yes No Has there been any change in your health this year?
- Yes No Have you ever been advised to premedicate with antibiotics for dental appointments? _____
- Yes No Prior adverse dental experiences Patient _____ Parent _____ Siblings _____
- Yes No Operations? If so, for what? _____
- Yes No Adenoid Removed
- Yes No Tonsils Removed

DO YOU HAVE OR HAD ANY OF THE FOLLOWING PROBLEM?

- Yes No Endocrine/ Thyroid problems Yes No Sleep Apnea
- Yes No Diabetes Yes No Kidney Problems, Dialysis
- Yes No Heart Trouble or Stroke Yes No Hepatitis, Jaundice, or Liver Disease
- Yes No Do you wear a pacemaker? Yes No Arthritis, Rheumatism
- Yes No Heart murmur, Mitral Valve Prolapse/Rheumatic Fever
- Yes No Abnormal bleeding or blood disorders Yes No Do you have cardiac valve prosthesis?
- Yes No Stomach or duodenal ulcer Yes No High or Low Blood Pressure
- Yes No Asthma, Allergies, Respiratory Problems Yes No Tuberculosis
- Yes No Chest Pains, Ankle Swelling, or Shortness of Breath
- Yes No Clotting Problems, Blood Transfusions Yes No Epilepsy or Seizures, Fainting
- Yes No Glaucoma or eye disorders Yes No Do you wear contacts?
- Yes No Tested positive to the HIV Virus/AIDS/STD? Yes No Transplants or any artificial prosthesis
- Yes No Depression or Anxiety Yes No Neurological problems
- Yes No Medical radiation/ Chemotherapy treatment
- Yes No Any other medical problems/ Operations? If yes, what:

ARE YOU ALLERGIC TO OR REACT ADVERSLY TO:

Yes No Local Anesthetics (Novocain) Yes No Latex, nickel
 Yes No Motrin, Advil (Ibuprofen), Aspirin, Tylenol Yes No Penicillin, other antibiotics
 Yes No Barbiturates, sedatives, sleeping pills Yes No Codeine
 Yes No Other: _____

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?

Yes No Antibiotics _____ Yes No Anticoagulants (blood thinners)
 Yes No Tranquilizers _____ Yes No Cortisone (steroids)
 Yes No Medication for high blood pressure _____ Yes No Medication for diabetes

 Yes No Aspirin _____ Yes No Ritalin, Prozac, other _____
 Yes No Nitroglycerin _____ Yes No Any substance abuse problem?
 Yes No Digitalis or other heart medication _____
 Yes No Osteoporosis medicines (Bisphosphonate, etc.)
 Yes No Are you presently taking any other prescription medications/Nonprescription? If yes, please list:

Learning Disability: Yes No ADD/ADHD: Yes No Autism: Yes No
Menarche/ Puberty: Yes No

DENTAL HISTORY

Any Facial/ Dental Injuries? Yes No What kind? _____
Does the patient play a musical instrument? Yes No What kind? _____
Does the patient have difficulty closing lips or biting with front teeth? Yes No
Oral Habits: Thumb sucking Finger sucking Nail biting Lip biting Mouth- breathing
 Tongue thrust Snoring
Tooth eruption rate: Normal Late Accelerated
Gag Reflex: None Moderate Strong
Speech and other Problems: _____
Who noticed the need for Orthodontic treatment first? Patient Parents Dentist Other: _____
Previous Orthodontic Treatment: Yes No Length of treatment _____ Year _____ Months
Orthodontist: _____ Previous Orthodontic Consultation? Yes No

TMJ HISTORY

Any pain in joints/ jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any popping or clicking of the jaw joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain/Ringing/Fullness in ear?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding or clenching of teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain or soreness the eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any tightness of jaws-joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck or shoulder pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any difficulty swallowing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty in opening mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No

GENERAL INFORMATION

What do you think is wrong with your teeth? _____

Do your front teeth hurt the roof of your mouth or lower front gum? Yes No

Any irritation to your lips/ tongue from irregular teeth? Yes No

Do Have Difficultly flossing? Yes No

Do you have difficultly closing your mouth or biting with your front teeth? Yes No

If treated with braces, what are your specific expectations? _____

Are you seeking orthodontic treatment with: Eagerness Willingness Complacency Resignation Antagonism

PERSON FILLING OUT PAPERWORK Self Other

For your information:

Some of the orthodontic appointments will infringe on school/ working time.

Possible side effects of orthodontics- cavities, enlargement of gums, root shortening, bone loss, joint disturbances and relapse.

Benefits of orthodontics – Esthetics, health, function and comfort.

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes later on to this history record, I will so inform this practice. Also, I give consent for this examination and I am legal authorized to do so.

DOCTOR SIGNATURE DATE

SIGNATURE DATE

SAINI ORTHODONTICS: NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (“HIPPA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act give you, the patient, significant new rights to understand and control how your health information is used. “HIPPA” provided penalties for covered entities that misuse personal health information.

As required by “HIPPA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

1. **Treatment** means providing, coordinating, or managing health care and related services by one or more health car providers. An example of this would include referring you for extractions of teeth, or a consultation with another physician or dentist.
2. **Payment** means such activities concerning reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
3. **Health Care Operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, management analysis and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders, via telephone, postcards, emails and text messages. Although we will make every attempt to speak with you, we often leave messages on answering machines.

We will always strive to respect everyone’s privacy, however, our patients are mostly treated in an “open bay” setting. In other words, our chairs are not located in individual rooms, rather they are located side by side.

We also recognize our patients and friends of the practice that have mentioned in newspaper/magazine articles, by placing such clippings on our bulletin boards. In addition, we place patient names and photos on display boards if they win office contests, started or finished treatment.

We like to help educate those who are pursuing a career in the health sciences or simply looking for answers to complex cases. Time to time, we invite physicians, dentists, medical students, dental students, and other professional students in our office for educational and consultation purposes.

We will always strive to ask for your permission before allowing any such individual to observe your treatment.

Any other uses and disclosures will be made with only your written authorization. You may revoke such authorization in writing and we are required to honor and abide that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
3. The right to inspect and copy your protected health information.
4. The right to receive an accounting of disclosures of protected health information.
5. The right to obtain a paper copy of this notice from us upon request.
6. The right to amend your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violation of the provisions of this notice or the policies, and procedures of our office. We can not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint, contact: The U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S. W. Washington, D.C. 20201 1-877-696-6775

SAINI ORTHODONTICS: NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability Act of 1996 (“HIPPA”), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Saini Orthodontics has the right to change its Notice of Privacy Practices from time to time and that I may contact Saini Orthodontics at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:

Relationship to Patient:

Signature:

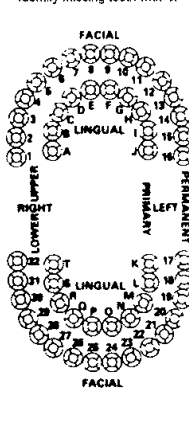
IF ANYONE SHOULD NOT HAVE ACCESS TO THE PATIENT’S MEDICAL OR FINANCIAL INFORMATION, PLEASE STATE THEIR NAME(S) HERE:

Date: _____

OFFICE USE ONLY: I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

ATTENDING DENTIST'S STATEMENT

Check one: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services		Carrier name and address				
PATIENT COVERAGE INFORMATION	1. Patient name first m.i. last	2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other	3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student school city	
	6. Employee/subscriber name and mailing address		7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate MM DD YYYY	9. Employer (company) name and address	
	10. Group number	11. Is patient covered by another dental plan? yes no If yes, complete 12-a. Is patient covered by a medical plan? yes no	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of other employer(s)	
	14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. number	14-c. Employee/subscriber birthdate MM DD YYYY	15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other		
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.				I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.		
Signed (Patient, or parent if minor) _____ Date _____			Signed (Insured person) _____ Date _____			
BILLING DENTIST	16. Name of Billing Dentist or Dental Entity		24. Is treatment result of occupational illness or injury?	No	Yes	
	17. Address where payment should be remitted City, State, Zip		25. Is treatment result of auto accident?	No	Yes	
	18. Dentist Soc. Sec. or T.J.N.	19. Dentist license no.	20. Dentist phone no.	27. If prosthesis, is this initial placement?	(If no, reason for replacement)	
	21. First visit date current series	22. Place of treatment Office Hosp. ECF Other	23. Radiographs or models enclosed No Yes How many?	29. Is treatment for orthodontics?	28. Date of prior placement	
26. Other accident?	If services already commenced enter:	Date appliances placed:	Mos. treatment remaining			
Identify missing teeth with "X"	30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.				For administrative use only	
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	
	Fee	Remarks for unusual services				
I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.				Total Fee Charged		
Signed (Treating Dentist) _____ License Number _____ NPI _____ Date _____			Max. Allowable			
			Deductible			
			Carrier %			
			Carrier pays			
			Patient pays			

See back of ID card for claim mailing address and customer service phone number.