Initials: _____

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

For Patients Under 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:_____

Attends School At:_____ Grade:_____Nickname:_____ Hobbies/Activities:_____

PARENT/GUARDIAN

Father's Full Name: _____ Title: ___Mr.___Dr. Other: _____

Address (if different than patient's): _____City: _____ State: _____

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

Occupation: _____ Position: _____ Email: _____

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

Mother's Full Name: _____ Title: __Mrs.__ Ms. __Dr. Other: _____

Address (if different than patient's): _____City: _____ State: _____

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

Occupation: _____ 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: _____

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? _____

Patient's Height: _____ Father's Height: _____ Mother's Height: _____

Brother's Ages: _____ Sister's Ages: _____ Patient Adopted: ____ Yes ____ No

Parents': ___ Single ___ Married ___ Separated ___ Divorced

Previous Orthodontic Experience: __ Father __ Mother __ Brother __ Sister __ Patient Where: _____

Initials: _____

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?

_____

Initials: _____

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: ___ Yes ___ No ADHD: ___ Yes ___ No

Menarche/ Puberty: ___ Yes ___ No Any Syndrome: ___Yes ___No Smoking: ___Yes ___No

Vaping : ___Yes ___No Autism: ___ 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 ___Clenching

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: _____

Pervious Orthodontic Treatment: ___ Yes ___ No Length of treatment _____ Year _____ Months

Orthodontist: _____ Previous Orthodontic Consultation? ___ Yes ___ No

Initials: _____

TMJ HISTORY

Any pain in joints/ jaw? ___ Yes ___ No Frequent Headaches? ___ Yes ___ No

Any popping or clicking of the jaw joints? ___ Yes ___ No Pain/Ringing/Fullness in ear? ___ Yes ___ No

Grinding of teeth? ___ Yes ___ No Pain or soreness the eyes? ___ Yes ___ No

Is there any tightness of jaws-joints? ___ Yes ___ No Neck or shoulder pain? ___ Yes ___ No

Is there any difficulty swallowing? ___ Yes ___ No Difficulty in opening mouth? ___ Yes ___ No

GENERAL INFORMATION

Is Patient Sensitive? ___ Yes ___ No Reserved: ___ Yes ___ No Outgoing: ___ Yes ___ No

What do you think is wrong with patient's teeth? _____

What are you expectations? _____

PERSON FILLING OUT PAPERWORK

Name: _____ Relationship to patient: _____

*If other than parent, legal guardianship paperwork is required before any treatment can be rendered

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 (PARENT/LEGAL GUARDIAN) DATE

Initials: _____

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.

Initials: _____

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 authourization. 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

Initials: _____

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:_____

Initials: _____

ATTENDING DENTIST'S STATEMENT

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name — first / m.i. / last
2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ 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 — ☐ self ☐ parent ☐ spouse ☐ 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.

Signed (Patient, or parent if minor) Date

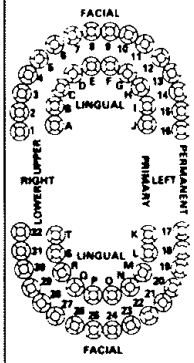
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (Insured person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted
City, State, Zip
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment — Office Hosp. ECF Other
23. Radiographs or models enclosed — No Yes How many?
24. Is treatment result of occupational illness or injury? — No Yes — If yes, enter brief description and dates
25. Is treatment result of auto accident?
26. Other accident?
27. If prosthesis, is this initial placement? — (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? — 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.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

31. 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.

Signed (Treating Dentist) License Number NPI Date

Total Fee Charged

Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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