BROOKLYN ORTHODONTICS

Patient Information

Name_____ ☐M ☐F Birthdate_____Home Phone_____

Address_____City_____State_____Zip_____

Email_____Cell Phone_____Cell Phone_____

Whom may we thank for referring you?_____Who is your dentist?_____

Person to contact in case of emergency_____Phone Number_____

Insurance Information

Name of Policyholder_____Relation to Patient_____

Birthdate_____Social Security #_____Employer_____

Insurance Company_____Insurance Phone_____

Health Information

Have you had any serious illnesses/ operations? ☐Yes ☐No Have you ever had a blood transfusion? ☐Yes ☐No

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control? ☐Yes ☐No

Check the box if you have, or have had, any of the following conditions:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer / Chemotherapy
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Coughing Up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur / Problems
- ☐ Hemophilia
- ☐ Hepatitis / HIV / AIDS
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney / Liver Disease
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic/Scarlet Fever
- ☐ Skin Rash
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers

List medications you are currently taking and the correlating diagnosis: **Allergies:**

_____ _____

_____ _____

_____ _____

Authorization and Release

To the best of my knowledge, this information is complete and correct. It is my responsibility to inform my doctor if I ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with the above listed company and assign directly to Dr. Mohamed Aljanabi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and ay disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed.

Signature of Patient/Parent/Guardian_____**Date**_____

Name of Patient/Parent/Guardian (Print)_____**Relationship**_____

HIPAA 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 it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry our treatment, payment, or health care options and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your doctor, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected information be disclosed to the heatlh plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: As required by law, Public Health issues as required by law, Communicable diseases, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law enforcement, Coroners, Funeral directors and Organ donation, Research, Criminal activity, Military activity and National security, Workers' Compensation, Inmates, Required Uses and Disclosure. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500. Other Permitted and Required Uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. **You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient/Parent/Guardian_____**Date**_____

Name of Patient/Parent/Guardian (Print) _____**Relationship**_____

BROOKLYN ORTHODONTICS

BROOKLYN SMILES
PRACTICE LIMITED TO PEDIATRIC DENTISTRY

We now have the ability to email, text, and/or send automated voice calls to you reminding you of your appointments. To receive this feature in the future, please read the consent below and sign.

Patients in our practice may be contacted via email, text messaging, and/or automated voice calls to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provider general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information by email, text, and/or automated voice calls from Brooklyn Orthodontics/Brooklyn Smiles.

Text Messages & Automated Voice Calls:

_____ (Patient/Parent Initials) I consent to receive text messages and/or automated voice calls from the practice at my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages/automated voice calls for appointment reminders, feedback, and general health reminders/information is:

(_____) _____-_____

Emails:

_____ (Patient/Parent Initials) I consent to receive email communications as stated above. The email that I authorize to receive appointment reminders and general health reminders, feedback, and information is:

_____

I understand that this request to receive emails, text messages, and/or automated voice calls will apply to all future appointment reminders/feedback/health information.

Patient Name (Print)_____

Patient/Parent Signature_____

Staff Initials_____ **Date**_____/_____/_____