1. PATIENT INFORMATION

Name ____

Birthdate ____

Address ________________________________ # _________

City _______________________ State ______ Zip ___________

Gender M ____ F ____

Patient Employer/School ____________________________

Dentist Name _____________________________________

Dentist Phone #_____________________________________

Date of Last Cleaning _____/_____/__________

How did you hear about us? __________________________

2. CONTACT INFORMATION

Patient # ____

Home # ____

Mother Name ____

Birthdate _____/_____/________SSN #___________________

Phone #____

Father Name ____

Birthdate _____/_____/________SSN #___________________

Phone #____

Emergency Contact ____________________________________

Phone # ____

3. ORTHODONTIC CONCERNS

What are your main concerns regarding the jaws and teeth?

- ☐ Crowding
- ☐ Spaces
- ☐ Overbite
- ☐ Overjet /buck teeth
- ☐ Don't like my smile
- ☐ Dental pain
- ☐ Teasing at school
- ☐ Jaw problems
- ☐ Gummy smile
- ☐ Gum disease/recession
- ☐ Thumb sucking
- ☐ Tongue habit
- ☐ Mouth breathing
- ☐ *Other* ____________________

Is this your first orthodontic evaluation? Yes_____ No_____

4. INSURANCE

Policyholder Name ________________________________

Birthdate ____/____/________SSN #___________________

Relationship to Patient ____________________________

Name of Insurance ________________________________

ID #______________________ Group #________________

Secondary insurance? ____Yes ____No

Name of Insurance ____________________________________

5. HEALTH HISTORY

Have you had any serious illnesses, operations, or a blood transfusion? ____ Yes ____ No

List any Allergies: _____________________________________

Medicines Currently Taking ______________________________

Do you have, or have you had, any of the following conditions:

- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ ADD/ADHD
- ☐ Blood Disease
- ☐ Cancer/Chemotherapy
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough (Persistent)
- ☐ Coughing up Blood
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart Murmur/Problems
- ☐ Hemophilia
- ☐ Hepatitis/HIV/AIDS
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney/Liver Disease
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers

FOR WOMEN

Are you nursing? ____Yes ____No

Taking birth control? ____Yes ____No

Are you pregnant? ____Yes* ____No

**If you are pregnant or there is a chance you may be pregnant, x-rays will not be taken*

AUTHORIZATION & 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 Al-Janabi/Brooklyn Orthodontics 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. Dr. Al-Janabi may use my health care information and ay disclose such information to the above-named insurance company and their agents for 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 __________________________

PRINT NAME of Patient/Parent/Guardian _______________________________________ RELATIONSHIP __________________

HIPAA NOTICE OF PRIVACY PRACTICES

The following Notice of Privacy Practices describes how we may use/disclose your protected health information, or PHI to carry our treatment, payment, or health care options and for other purposes that are permitted or required by law. It describes your rights to access and control your PHI (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 & DSCLOSURES OF PROTECTED HEALTH INFORMATION Your PHI 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 practice, and any other use required by law.

TREATMENT We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services, including the coordination/management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

PAYMENT Your PHI may be used to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS We may use or disclose your protected health information 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. 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 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.

AUTOMATED APPOINTMENT REMINDERS You may be contacted via email, text, and/or automated voice calls to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment. If you opt out of appointment reminders, we will not contact you prior to your appointments. You will still be held responsible for keeping track of your appointments. Whichever option you choose will apply to all future communications.

PLEASE *INITIAL* ONE OF THE FOLLOWING OPTIONS

________ **I CONSENT** to receiving appointment reminders, healthcare communications, and information by email, text, and/or automated voice calls from Brooklyn Orthodontics.

Phone:
- (________)________-____________
- (________)________-____________

Email:
- ____
- ____

________ **I DO NOT CONSENT** to receiving appointment reminders, healthcare communications, and information by email, text, or automated voice calls.

SIGNATURE of Patient/Parent/Guardian ____ DATE ___________________________

PRINT NAME of Patient/Parent/Guardian ____ RELATIONSHIP ___________________