MINT HILL ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

MINT HILL ORTHODONTICS has a legal duty to keep your personal health information private and to:

1. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical and dental information.
2. Follow the terms of the current notice.
3. Notify you in a timely manner of an accidental disclosure of your private health information.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: When we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION

The following describes different ways that we use and disclose your private health information. Not every use or disclosure is listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical or dental information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. We may use your PHI to provide you with dental treatment or services. We may disclose medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.

2. We may use and disclose your PHI for payment purposes. A bill may be sent to you, a third-party payer or to a collection agency. The information on or accompanying the bill may include your treatmentinformation.
3. We will not sell or use your personal health information for marketing or fundraising purposes without first obtaining your signed authorization.
4. We are required to inform you if there are any financial conflicts of interest with us and the products or services utilized by us.
5. If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.
6. You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, we are required to send them as directed and in a timely manner.

PATIENT ACKNOWLEDGEMENT

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment or 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/GUARDIAN NAME: (PRINT)_____

RELATIONSHIP TO PATIENT:_____

SIGNATURE: _____ **DATE:** _____

MINT HILL
ORTHODONTICS

WELCOME TO OUR OFFICE

Date: _____

Patient's Name: _____ Date of Birth: _____
FIRST LAST

Mailing Address: _____
STREET CITY STATE ZIP

Email: _____ Cell Phone: _____

Referred By: _____ General Dentist Name: _____

School (if applicable): _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
FIRST LAST

Billing Address (if different): _____
STREET CITY STATE ZIP

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Relationship to Patient: _____

DENTAL INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ Policy Holder SSN: _____

Insurance Company: _____ ID #: _____

Insurance Co. Phone Number: _____

Employer: _____

SECONDARY DENTAL INSURANCE

Policy Holder Name: _____ DOB: _____ Policy Holder SSN: _____

Insurance Company: _____ ID #: _____

Insurance Co. Phone Number _____

Employer: _____

MINT HILL ORTHODONTICS

MEDICAL HISTORY

Yes No

- ☐ ☐ Do you need to pre medicate for appointments?
- ☐ ☐ Experienced bone fractures or any major accidents?
- ☐ ☐ Rheumatoid or arthritic conditions
- ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ Kidney problems?
- ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ Diabetes? If yes, Type I or Type II? _____
- ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ Stomach ulcer or hyper acidity ?
- ☐ ☐ Polio, mononucleosis or pneumonia?
- ☐ ☐ Problems of the immune system?
- ☐ ☐ AIDS or HIV Positive?
- ☐ ☐ Hepatitis, jaundice, or liver problems?
- ☐ ☐ Fainting spells, seizures, epilepsy or neurological problems?
- ☐ ☐ Mental health disturbance or behavioral problems?
- ☐ ☐ Vision, hearing, tasting or speech difficulties ?
- ☐ ☐ Loss of weight recently or poor appetite?
- ☐ ☐ High or low blood pressure?
- ☐ ☐ Chest pain or shortness of breath
- ☐ ☐ Cardiovascular problems (heart attack, stroke, heart defect or murmur,arteriosclerosis, coronary insufficiency, angina, or rheumatic heart disease)?
- ☐ ☐ Female Patients: Are you pregnant?
- ☐ ☐ Any other medical conditionsthat we should be aware of? _____
- ☐ ☐ Are you taking any medication, nutrient supplements, herbal medications, or prescription medicine? If yes, please name medication and what it is taken for:

If you answered YES to any of the questions above, please specify:

Allergies or reactions to any of the following:

Yes No

- ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ Metal (jewelry, clothing snaps)
- ☐ ☐ Medication, if yes please specify: _____
- ☐ ☐ Food, if yes please specify: _____
- ☐ ☐ Other, if yes please specify: _____

Dental History

Yes No

- ☐ ☐ Chipped or otherwise injured baby or permanentteeth?
- ☐ ☐ Teeth sensitive to hot or cold (teeth throb or ache)?
- ☐ ☐ Periodontal (gum) or bone problems?
- ☐ ☐ Food impaction between teeth?
- ☐ ☐ History ofspeech problems?
- ☐ ☐ Mouth breathing, snoring or difficulty breathing?
- ☐ ☐ Any pain in jaw or ringing in the ears?
- ☐ ☐ Difficulty encountered in chewing or jaw opening ?
- ☐ ☐ Have you ever been treated for TMD or TMJ problems?
- ☐ ☐ Any teeth irritating cheek, lip, tongue, or palate?
- ☐ ☐ Any wisdom tooth problems?
- ☐ ☐ Had any serious trouble associated with any previous dental treatment?
- ☐ ☐ If recommended, would you object to wearing orthodontic appliances(braces)?
- ☐ ☐ History of thumb Sucking?

EMERGENCY INFORMATION

Name: _____

Phone: _____ Relationship to Patient: _____