epic smiles® | invisalign® PROVIDER

Orthodontic Patient Registration

Patient Name: _____

Address: Street _____ City _____ State _____ Zip _____

Date of Birth: _____ SSN: _____ Phone Number: _____

Email Address: _____

Please list your chief concerns: _____

_____

_____

How Did You Here about Epic Smiles? ☐ Tv ☐ Radio ☐ Referral ☐ Web search ☐ Facebook ☐ Instagram

☐ Other: _____

Dental Insurance Company

Dental Insurance Company Name: _____

Group #: _____ ID#: _____

Insurance Phone Number: _____

Subscriber Name: _____ Date of Birth: _____

Responsible Party Information (Parent or Guardian)

Name: _____

Relationship to Patient: _____

Parent or Guardian Social Security Number: _____

Phone Number: ☐ Home ☐ Cell _____

Medical History

Sex: ☐ Male ☐ Female ☐ Other _____

DO YOU HAVE OR HAVE YOU EVER HAD _____

ADHD/ADD	☐ Yes	☐ No	Nickel Allergy	☐ Yes	☐ No
Joint Swelling or Arthritis	☐ Yes	☐ No	Mouth Breathing	☐ Yes	☐ No
Prolonged Bleeding	☐ Yes	☐ No	Known missing permanent teeth	☐ Yes	☐ No
Endocrine Problems	☐ Yes	☐ No	Known extra permanent teeth	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Tongue Thrust problems	☐ Yes	☐ No
Bone Disorders	☐ Yes	☐ No	Speech Problems	☐ Yes	☐ No
Have you ever taken or are you currently taking Bisphosphonates	☐ Yes	☐ No	Pain, popping or locking when opening or closing jaw	☐ Yes	☐ No
Hepatitis or Liver Problems	☐ Yes	☐ No	Muscle tenderness or stiffness in jaw or neck	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No	Do you clench or grind your teeth	☐ Yes	☐ No
AIDS or HIV	☐ Yes	☐ No	Ringing in the ears	☐ Yes	☐ No

Medical History (Continued)

DO YOU HAVE OR HAVE YOU EVER HAD _____

Cancer	☐ Yes	☐ No	Spells of dizziness	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Previous treatment of TMJ or jaw problems	☐ Yes	☐ No
Latex Allergy	☐ Yes	☐ No	Use Botox or fillers	☐ Yes	☐ No
Wear a mouth guard for sports or other activities	☐ Yes	☐ No	Interested in Botox or fillers	☐ Yes	☐ No

Asthma	☐ Yes	☐ No	(if yes) Medications: _____
Heart Trouble/ Murmur	☐ Yes	☐ No	(if yes) Medications: _____
Artificial Joint(s)	☐ Yes	☐ No	(if yes) What Year: _____
Tonsils Removed	☐ Yes	☐ No	(if yes) What Year: _____
Are you Pregnant	☐ Yes	☐ No	(if yes) # Months: _____
Seasonal Allergy Medications	☐ Yes	☐ No	(if yes) Describe: _____
Drug Allergies	☐ Yes	☐ No	(if yes) List: _____
Thumb, finger or lip sucking habits	☐ Yes	☐ No	(if yes) Until What Age: _____
Have you had teeth extracted	☐ Yes	☐ No	(if yes) What Year: _____
Previous Orthodontic Evaluation	☐ Yes	☐ No	(if yes) What Year: _____
Previous Orthodontic Treatment	☐ Yes	☐ No	(if yes) What Year: _____
Type: ☐ Braces ☐ Aligners	☐ N/A	Other: _____	
Currently under a doctor's care	☐ Yes	☐ No	(if yes) What for? _____

Printed Name of Person Filling out Form

Date of Birth

Signature

Date

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Epic Smiles Centers, we are required to keep your health information secure and confidential, by law.

Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We will need to release some or all of your health information, when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services in writing:

(200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.eov).

You will not be retaliated against for filing a complaint.

Please contact our HIPAA Compliance Officer, David Willens at (248) 482-2768 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

I have received a copy of the Epic Smiles Centers Notice of Privacy Practices

Acknowledgement: _____ Date _____