HIGGINBOTTOM
ORTHODONTICS
SMILE WITH STYLE

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ADULT REGISTRATION

Patient Name	Nickname	Soc. Sec. #	
Street Address		Birthdate	Age
City	State	Zip	
Home Phone	Business Phone	Marital Status	
Cell Phone	Email		
Patient's Employer		Occupation	
Employer Address		Business Phone	
Spouse's Name	Birthdate	Soc. Sec. #	

MEDICAL HISTORY

Physician_____ Date of Last Visit_____

Address_____ Phone_____

Please check YES or NO (If YES, please fill out details)

☐ YES ☐ NO Are you taking any medications?_____

☐ YES ☐ NO Are you taking any medications for osteoporosis (example-Fosamax or Actonel)_____

☐ **YES** ☐ **NO** **Are you allergic to any medication?**_____

☐ YES ☐ NO Do you have a history of a major illness?_____

☐ YES ☐ NO Have you had any operations?_____

☐ YES ☐ NO Have you ever been involved in a serious injury?_____

☐ YES ☐ NO Have you seen a physician in the last 12 months? Why?_____

☐ YES ☐ NO Has the patient been ill for more than 5 days in the last 12 months? Name the illness:_____

Patient name:_____

Please check any of the medical conditions below that you have had or currently have:

☐ Abnormal Bleeding/Hemophilia	☐ Convulsions	☐ Herpes	☐ Radiation/Chemotherapy
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Arthritis	☐ Dizziness	☐ HIV/AIDS	☐ Thyroid Problems
☐ Asthma or Hayfever	☐ Epilepsy	☐ Kidney Problems	☐ Tuberculosis
☐ Allergies	☐ Gastrointestinal Disorder	☐ Nervous Disorders	☐ Tumor or Cancer
☐ Back & Neck Pain	☐ Heart Problems	☐ Osteoporosis	
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pneumonia	
☐ Congenital Heart Defect	☐ Hepatitis/Liver Problems	☐ Prolonged Bleeding	

Are there any medical conditions we have not discussed that you feel we should be aware of?_____

_____

DENTAL HISTORY

General Dentist_____ **Date of Last Visit**_____

Address_____ City_____ State_____

☐ Yes ☐ No Are you concerned about the appearance of your teeth?_____

☐ Yes ☐ No Do you have difficulty in chewing or swallowing your food?_____

☐ Yes ☐ No Have any of your teeth been removed by a dentist/oral surgeon?_____

☐ Yes ☐ No Have you ever lost or chipped any teeth?_____

☐ **Yes** ☐ **No** **Have there been any injuries to face, mouth, or teeth?**_____

☐ Yes ☐ No Is any part of your mouth sensitive to temperature? Where?_____

☐ Yes ☐ No Is any part of your mouth sensitive to pressure? Where?_____

☐ **Yes** ☐ **No** **Do you have any type of thumb, finger or tongue habit?**_____ **Age when stopped**_____

☐ Yes ☐ No Are you a mouth breather?_____

☐ Yes ☐ No Have you ever seen an orthodontist? If yes, who and when? _____

☐ **Yes** ☐ **No** **Has anyone in your family received orthodontic treatment?**_____

How did they feel about the result?_____

☐ Yes ☐ No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____

☐ **Yes** ☐ **No** **Are you aware of your jaw clicking or popping?**_____

☐ Yes ☐ No Are you aware of clenching your teeth during the day?_____

☐ Yes ☐ No Have you ever been told that you grind your teeth?_____

☐ **Yes** ☐ **No** **Do you bite your lips, tongue, fingernails, pencils or other objects?**_____

☐ Yes ☐ No Do you have "tension" headaches?_____

☐ Yes ☐ No Have you ever experienced chronic ringing in the ears?_____

☐ Yes ☐ No Do you have sleep apnea or do you snore?_____

☐ **Yes** ☐ **No** **Have you had your tonsils or adenoids removed?**_____

☐ Yes ☐ No Are you aware that some appointments will be during school/work hours?_____

☐ Yes ☐ No Does any member of your family or close relatives have a similar arrangement of teeth or a similar appearance in jaws?_____

☐ Yes ☐ No Do you brush your teeth in the morning?_____

☐ Yes ☐ No after lunch?_____

☐ Yes ☐ No after dinner?_____

☐ Yes ☐ No before bed?_____

☐ Yes ☐ No Do your gums bleed when you brush?_____

Patient name:_____

If any of your relatives have been seen in this office, please list their names:_____
What is your reason for seeking orthodontic treatment?_____
What is your attitude toward receiving orthodontic treatment?_____

FEMALE PATIENTS ONLY:

☐ Yes ☐ No Are you pregnant?_____

How did you learn about our office?_____
Whom may we thank for referring you?_____
Please list some hobbies or interests_____

REVIEWED BY:_____ DATE:_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my orthodontist or any other member of his team responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE:_____ DATE:_____

IF YOU HAVE DENTAL INSURANCE WITH ORTHODONTIC COVERAGE, PLEASE PROVIDE A COPY OF YOUR CARD AT YOUR INITIAL CONSULTATION APPOINTMENT.

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.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law.
This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

How We Will Use or Disclose Your Health Information

Treatment: We will use your health information for treatment. For example, information obtained by the orthodontist or other members of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your orthodontist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations, so that your dentist will know how you are responding to treatment. We will also provide your dentist, or a subsequent healthcare provider, with copies of various reports that should assist him or her in treating you.
Payment: We will use your health information for payment. For example, a bill may be sent to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
Health Care Operations: We will use your health information for our regular health care operations. For example, we may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in a continued effort to improve the quality and effectiveness of the services we provide.
Business Associates: We may enter into contracts with persons or entities known as business associates that provide services to or perform functions on our behalf. Examples include our accountants, consultants, and attorneys. We may disclose your health information to our business associates so they can perform the job we have asked them to do, once they have agreed in writing to safeguard your information.
Notification: We may use or disclose information to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided to us, e.g., on an answering machine.
Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
Appointment Reminders / Health Benefits: We may contact you to provide appointment reminders or information about treatment alternatives or other health benefits that may be of interest to you.
Research: We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also disclose your health information to people preparing to conduct a research project, so long as the health information is not removed from us. We may also use and disclose your health information to contact you about the possibility of enrolling in a research study.
Fundraising: We may contact you as part of our fundraising efforts; however, you may opt-out of receiving such communications.
Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs established by law.
Public Health Activities: As required by law, we may disclose your health information to public health, or legal authorities, charged with preventing or controlling disease, injury, or disability.
Health Oversight Activities: We may disclose your health information to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.
Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, health information necessary for your health and the health and safety of other individuals.
Judicial and Administrative Proceedings: We may disclose your health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.
Law Enforcement Purposes / Serious Threat to Health or Safety: We may disclose your health information to enforcement officials for law enforcement purposes under certain circumstances and subject to certain conditions. We may also disclose your health information to prevent or lessen a serious and imminent threat to a person or the public (when the disclosure is made to someone we believe can prevent or lessen the threat) or to identify or apprehend an escapee or violent criminal.
Victims of Abuse, Neglect, and Domestic Violence: In certain circumstances, we may disclose your health information to appropriate government authorities if there are allegations of abuse, neglect, or domestic violence.
Essential Government Functions: We may disclose your health information for certain essential government functions (e.g., military activity and for national security purposes).
The following uses and disclosures will be made only with your authorization: (i) with limited exceptions, uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in this notice. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

Your Health Information Rights

Although your health record is the physical property of this office, you have the following rights with respect to your health information:

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, our general healthcare operations, and/or to a particular family member, other relatives or close personal friend. We ask that such requests be made in writing on a form provided by us. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it, except as provided below.

- If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We ask that such requests be made in writing on a form provided by us. We are required to abide by such a request, except where we are required by law to make a disclosure. We are not required to inform other providers of such a request, so you should notify any other providers regarding such a request.

- You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing, and submitted to the Privacy Officer. We will attempt to accommodate all reasonable requests.

- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If we maintain your health information electronically in a designated record set, you may obtain an electronic copy of the information. If you request a copy (paper or electronic), we will charge you a reasonable, cost-based fee.

- If you believe that any health information in your record is incorrect, or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by us to make such requests. For a request form, please contact the Privacy Officer.

- You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed six years), as required by law. We ask that such requests be made in writing on a form provided by us. Please note that accounting does not include all disclosures, e.g., disclosures to carry out treatment, payment, or healthcare operations and disclosures made to you or your legal representative or pursuant to an authorization. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.

- You have the right to be notified following a breach of your unsecured protected health information.

- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

For More Information or to Report a Problem

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.
For more information or to file a complaint with us, contact our Privacy Officer by phone or mail as follows: Higginbottom Orthodontics. To file a complaint with the Secretary of HHS, send your complaint to: The Regional Office of Civil Rights.
If you have any questions or want more information about this Notice of Privacy Practices, please contact our Privacy Officer.

Acknowledged By: _____ Date: _____

Signature of Patient or Personal Representative