Martinez Orthodontics

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Las Vegas, NV 89118
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PATIENT INFORMATION

Patient's name: _____M_____ F_____
Last *First* *Middle*

Address: _____
Street *City* *Zip*

Home Phone: _____Birthdate: _____ Age: ____ Social Security#_____

Name of Patient's Dentist: _____ Date of Last Visit: _____

Email Address: _____ How did you hear about our office?

Friend_____ Relative_____ Dentist_____

Internet_____ Social Media _____

TREATMENT OPTIONS

What treatment options are you interested in?

Metal Braces ☐ Clear Braces ☐ Retainers ☐ Invisalign Teen ☐ Invisalign ☐

What is you main concern about your smile? _____

How often do you Brush_____ Floss_____

DENTAL INSURANCE INFORMATION

Primary Insured's Names_____ Insured's Social Security# _____

Insurance Company_____ Group No. _____Phone Number_____

Member ID No _____ Insured's DOB_____

Do you have dual coverage? Yes_____ No_____

Secondary Insured's Name_____ Insured's Social Security #_____

Insurance Company_____Group No._____ Phone Number_____

Member ID No. _____Insured's DOB_____

Is there anyone else who is going to be involved in the decision to start treatment? Yes ☐ No ☐

Do you have allergies to Latex, Vinyl, Acrylic? (gloves, balloons)

Thumb, finger, or sucking habit (tongue thrusting)? Yes ☐ No ☐

Women Only: Are you pregnant? Yes ☐ No ☐

Have you had another orthodontic consultation? Yes ☐ No ☐

Are there allergies or health concerns we should be aware of? Yes ☐ No ☐

Are you anxious to start treatment? Yes ☐ No ☐

I affirm that the above information is correct to the best of my knowledge.

X_____ Signature (Parents signature if minor) Date:_____

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CONSENT TO EXAMINE PATIENT

It is necessary to take diagnostic x-rays in order to determine an appropriate treatment plan and patient diagnosis.

I hereby authorize the attending doctor and staff to take these diagnostic x-rays and prepare an orthodontic treatment evaluation for:

_____	_____
Patient Name	Patient/Legal Guardian Signature
_____	_____
Relationship to Patient	Date

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NOTICE OF PRIVACY PRACTICES (HIPAA)

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

Your protected health information (i.e. Individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- ☐ *To* other health care providers (i.e. your general dentist, oral surgeon, etc) in connection with our rendering orthodontic treatment to you (i.e. to determine the results of cleanings, surgery, etc.)
- ☐ *To* third party payors or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, dates of payment, etc.).
- ☐ *To* certifying, licensing and accrediting bodies (i.e. the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation.
- ☐ *Int*ernally, to all staff members who have any role in your treatment.
- ☐ *To* other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- ☐ *To* your family and close friends involved in your treatment.
- ☐ *To* contact you in order to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- ☐ *To* email your xrays, photos and treatment plan to your other doctors as needed.
- ☐ *To* leave messages or email you regarding upcoming appointments.
- ☐ *Any o*ther uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

<u>Your rights regarding your health information:</u>

- ☐ *You* may ask us to communicate with you in a confidential manner, ask to see or obtain photocopies of your health information and/or ask us to amend your health information if you feel that it is inaccurate or incomplete.
- ☐ *I* give permission for my/my child's photo to be displayed in this office, social media accounts, and website.

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received, read and reviewed a copy of this notice of Privacy Practices, the consent to treatment and office procedures. I authorize use of my signature on and release of information for insurance submissions.

_____ _____

Signature of Responsible Party Date