Welcome to Bergenfield Orthodontics

The benefits of a happy, healthy smile are immeasurable!
A beautiful smile is a wonderful asset.

Please fill out this form to the best of your ability. The better we communicate, the better we can serve you.

PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Phone_____ Birthdate_____ Social Security # _____

Email address_____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Mailing Address _____
Street City Zip

Home phone_____ Work phone _____ Cell phone_____

Email address _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

DENTAL INSURANCE INFORMATION

Insured's Name_____

Insured's Birthdate_____ Insured's Social Security # _____

Insurance Company_____ID No._____Group No. _____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

Parent Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If yes, please fill in details)

Yes	No	Is the patient taking any medication? _____
Yes	No	Is the patient allergic to any medication? _____
Yes	No	History of a major illness? _____
Yes	No	Has the patient had any surgeries? _____
Yes	No	Ever been involved in a serious accident? _____
Yes	No	Have seen a physician in the last 12 months? Why? _____
		Female Patients only:
Yes	No	Has menstruation started? _____
Yes	No	Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

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 _____

What concerns you most about your teeth? _____

Yes	No	Is the patient presently in any dental pain? _____
Yes	No	Ever experienced any unfavorable reaction to dentistry? _____
Yes	No	Do gums bleed when brushing? _____
Yes	No	Any type of thumb or tongue habit? _____
Yes	No	Is the patient a mouth breather? _____
Yes	No	Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes	No	Is the patient sensitive or self-conscious about his/her teeth? _____

By signing below, you acknowledge and accept the following:

- I understand the medical and dental history form and all the proceeding health history answers I have given are true.
- I am covered by my insurance, and I assign directly to Bergenfield Orthodontics all insurance benefits, otherwise payable to me. I understand that I am responsible for paying any treatment fees, co-payment, and/or deductible that my insurance may not cover.
- I authorize the orthodontist to release information to my insurance to secure the payment of benefits. I authorize the use of his/her signature on my insurance submissions, both electronic and manual.
- I authorize records to be used for standard record keeping and for seeing second opinions from peers or other clinicians, if deemed necessary by the treating clinician.

Signature: _____Date: _____

THE FEDERAL GOVERNMENT REQUIRES ALL MEDICAL OFFICES TO MAKE PATIENTS AWARE THAT THEY HAVE RIGHTS REGARDING THE USE OF THEIR PERSONAL HEALTH INFORMATION. OUR NOTICE OF PRIVACY PRACTICES IS AVAILABLE FOR YOUR REVIEW AT THE FRONT DESK.

BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ACCORDING TO THE NOTICE OF PRIVACY PRACTICES AVAILABLE TO YOU AT OUR FRONT DESK.

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION.
THESE RIGHTS ARE GIVEN TO ME UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). I UNDERSTAND THAT BY SIGNING THIS CONSENT I AUTHORIZE YOU TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRY OUT:

- ✓ TREATMENT (INCLUDING DIRECT OR INDIRECT TREATMENT BY OTHER HEALTHCARE PROVIDERS INVOLVED IN MY TREATMENT).
- ✓ THE DAY-TO-DAY HEALTHCARE OPERATIONS OF YOUR PRACTICE.
- ✓ I HAVE ALSO BEEN INFORMED OF, AND GIVEN THE RIGHTS TO REVIEW AND SECURE A COPY OF YOUR NOTICE OF PRIVACY PRACTICES WHICH CONTAINS A MORE COMPLETE DESCRIPTION OF THE USE AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION, AND MY RIGHTS UNDER HIPAA. I UNDERSTAND THAT YOU RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE FROM TIME TO TIME AND THAT I MAY CONTACT YOU AT ANY TIME TO OBTAIN THE MOST CURRENT COPY OF THIS NOTICE.
- ✓ I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW MY PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, BUT THAT YOU ARE NOT REQUIRED TO AGREE TO THESE REQUEST RESTRICTIONS.
- ✓ HOWEVER, IF YOU DO AGREE, YOU ARE BOUND TO COMPLY WITH THIS RESTRICTION. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, IN WRITING, SIGNED BY YOU.

THE PATIENT UNDERSTANDS THAT:

- ✓ WE WILL NOT RELEASE INFORMATION TO ANY FUTURE DOCTOR, ATTORNEY, LIFE INSURANCE COMPANY, OR WORKMAN'S COMPANY WITHOUT YOUR WRITTEN CONSENT.
- ✓ PROTECTED HEALTH INFORMATION MAY BE USED FOR TREATMENT THROUGH ONE OF YOUR CURRENT DOCTORS (SUCH AS YOUR PRIMARY CARE PHYSICIAN OR A SPECIALIST REFERRAL), PAYMENT WITH YOUR INSURANCE COMPANY, OR HEALTHCARE OPERATIONS WITHIN OUR OFFICE.
- ✓ BERGENFIELD ORTHODONTICS RESERVES THE RIGHT TO CHANGE THE NOTICE OF PRIVACY PRACTICES.
- ✓ THE PATIENT HAS THE RIGHT TO RESTRICT THE USE OF THEIR INFORMATION, BUT BERGENFIELD ORTHODONTICS DOES NOT HAVE TO AGREE TO THESE RESTRICTIONS IF, FOR EXAMPLE, IT INTERFERES WITH PAYMENT, DAILY OPERATIONS, OR PROVIDING QUALITY HEALTH CARE.
- ✓ THE PATIENT MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME AND ALL FUTURE DISCLOSURES WILL THEN CEASE.

BERGENFIELD ORTHODONTICS MAY CONDITION TREATMENT UPON THE EXECUTION OF THIS CONSENT (FOR EXAMPLE, YOU MAY BE REQUIRED TO PAY YOUR VISIT AT THE TIME OF SERVICE)

DATE _____

RELATIONSHIP TO PATIENT_____

SIGNATURE_____