

# WELCOME TO HUDSON & HO ORTHODONTICS

Account # \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Last) (First) (Middle)

Today's Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
(Street) (City) (State) (Zip)

In case of an Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

**Responsible Party**  Check if Self

**If you are a Minor** → Parents are:  Married  Widowed  Divorced  Separated Patient Lives With? \_\_\_\_\_

**MOTHER'S NAME** \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Home # \_\_\_\_\_  
 Work # \_\_\_\_\_  
 Cell # \_\_\_\_\_

Employed By \_\_\_\_\_

Occupation \_\_\_\_\_

**FATHER'S NAME** \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Home # \_\_\_\_\_  
 Work # \_\_\_\_\_  
 Cell # \_\_\_\_\_

Employed By \_\_\_\_\_

Occupation \_\_\_\_\_

**HOW WERE YOU REFERRED?**

Dentist  Family  Friends  
 Drive-By  Website  Invisalign  
 Other \_\_\_\_\_

Referral's Full Name \_\_\_\_\_  
\_\_\_\_\_

Please check either Yes or No to the following

Yes  No – Has this patient ever seen been for any other orthodontic consultation?  
If Yes, who was the orthodontist? \_\_\_\_\_ Date \_\_\_\_\_

Yes  No – Has this patient ever had previous orthodontic treatment?  
Who was the orthodontist? \_\_\_\_\_ City \_\_\_\_\_

Yes  No – Has anyone in your family had orthodontic treatment in our office?

**PRIMARY INSURED INFORMATION**

Name of Insured \_\_\_\_\_  
Insured's DOB \_\_\_\_\_ Insured's SSN or ID \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Address of Insured \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employed by \_\_\_\_\_  
Work Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Dental Ins. Co. Name \_\_\_\_\_  
Ins Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Ins Group # \_\_\_\_\_ Ins Phone \_\_\_\_\_

**SECONDARY INSURED INFORMATION**

Name of Insured \_\_\_\_\_  
Insured's DOB \_\_\_\_\_ Insured's SSN or ID \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Address of Insured \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employed by \_\_\_\_\_  
Work Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Dental Ins. Co. Name \_\_\_\_\_  
Ins Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Ins Group # \_\_\_\_\_ Ins Phone \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

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

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Are you taking any medication? _____                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you allergic to any medication? Latex or Nickel? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a history of a major illness? _____            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any major operations? _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been involved in a serious accident? _____   | <input type="checkbox"/> | <input type="checkbox"/> |

**Female Patients only:**

- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
| 6. Are you pregnant? _____         | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has menstruation started? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

8. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
ADD/Autism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Radiation/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	Severe/Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	STD's	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV-AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Cancer	<input type="checkbox"/>	<input type="checkbox"/>

9. Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

**PATIENT DENTAL HISTORY**

Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

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

- |  | NO                       | YES                      |       |
|--|--------------------------|--------------------------|-------|
| 1. Are you presently in any dental pain?                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Have you ever experienced any unfavorable reaction to dentistry?      | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Have you ever lost or chipped any teeth?                              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Have there been any injuries to your face, mouth or teeth?            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Is any part of your mouth sensitive to temperature or pressure?       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Have you had your tonsils/adenoids removed?                           | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Do your gums bleed when you brush?                                    | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. If the patient is under age 16, height of parent? Mom _____ Dad _____ |                          |                          |       |

**AUTHORIZATION TO OBTAIN INFORMATION**

I authorize any dentist, physician, medical practitioner, hospital, clinic, any dental or medically related facility to release any information available to help us with diagnosis and prognosis of my or my child's case. Information obtained by use of this authorization will not be released by Hudson & Ho Orthodontics without my express permission. I understand where appropriate, credit bureau reports may be obtained.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ANSWERS ON THE FRONT & BACK SIDE OF THIS FORM ARE TRUE AND CORRECT. IF EVER THERE IS A CHANGE IN HEALTH, OR ANY MEDICATION CHANGE, I WILL INFORM THE OFFICE.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

FOR OFFICE USE

DATE \_\_\_\_\_

ASSISTANT \_\_\_\_\_

X-RAYS TAKEN \_\_\_\_\_

CASE # \_\_\_\_\_

MIDLINE

R | L

OCCUSAL PLANE

R | L

## NOTICE OF PRIVACY PRACTICES (DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations. **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services. **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you by phone, mail or email to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting disclosure of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of today and we are required to abide by the terms of the Notice of Privacy currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257

# Notice of Privacy Practices Acknowledgement

## HUDSON & HO ORTHODONITCS

428 Arden Ave, Suite 101

Glendale, California 91203

Telephone (818) 244-2121

Fax (818) 244-1956

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private 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 Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason