Gimlen Orthodontics

Date: _____

PATIENT INFORMATION

Patient Name:

_____

Last Name First Name Middle Name

What patient prefers to be called: _____

Patient Address:

_____

Street City State Zip

Date of Birth: _____/_____/_____ Sex: Male _____ Female _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Reminder preference: Text_____ Email ____

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

RESPONSIBLE PARTY INFORMATION

* If you are over age 18, this is you *

Responsible Party : _____

Last Name First Name Middle Name

Responsible Party Address: _____

Street City State Zip

Primary Phone: _____ Secondary Phone: _____

Date of Birth: _____/_____/_____ Sex: Male _____ Female _____

Social Security Number: _____ Relationship to Patient: _____

Is this responsible party financially responsible for charges: Yes _____ No _____

Is this the primary person who will bring patient to appointments: Yes _____ No _____

Dental Insurance Company: _____

Subscriber ID/Social Security Number: _____ Group Number: _____

Dental Insurance Phone Number: _____

Insured/Responsible Party's Employer: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

_____

Initial Here

SECONDARY RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
Last Name First Name Middle Name

Responsible Party Address: _____
Street City State Zip

Primary Phone: _____ Secondary Phone: _____

Date of Birth: _____/_____/_____ Sex: Male _____ Female _____

Social Security Number: _____ Relationship to Patient: _____

Is this responsible party financially responsible for charges: Yes _____ No _____

Is this the primary person who will bring patient to appointments: Yes _____ No _____

Dental Insurance Company: _____

Subscriber ID/Social Security Number: _____ Group Number: _____

Dental Insurance Phone Number: _____

Insured/Responsible Party's Employer: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
I fully understand I am solely responsible for any balance not paid by my insurance company.

_____
Initial Here

Patient Medical/Dental Information

Dentist: _____ Physician: _____
Please check any of the following for which the patient has been treated:
Bone Disorders _____ Anemia _____ Fainting or Dizziness ____ Epilepsy _____ Heart Trouble____
List any recent medical problems: _____
Drugs or medications currently taking: _____
Pre-medication required Yes _____ No _____
Please list any drug allergies or sentitivities: _____
Does patient have any sensory issues? Yes _____ No _____
Does patient have latex sensitivity Yes _____ No _____
Does patient use tobacco Yes _____ No _____
Have bisphosphonates been taken Yes _____ No _____
Have tonsils/adenoids been removed Yes _____ No ____
Thumb/finger sucker Yes _____ No _____ until what age _____
Mouth breather while awake Yes _____ No _____ Mouth breather while asleep Yes _____ No ____
Do you have pain or noise in your jaw joint (TMJ) Yes _____ No _____ Right _____ Left _____
Have you been informed of any missing permanent teeth or extra permanent teeth Yes _____ No _____
Have you consulted with an orthodontist previously? Yes _____ No _____
Chief concern/reason for visit today _____
Treatment preference: Traditional Braces _____ Clear Braces _____ Invisalign ____ New Retainer ____

Amy A. Gimlen, DDS, MS, Inc.
Privacy Practices Notice (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 insurance 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;
- Internally, 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; and/or,
- We may contact you 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 or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.
Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive and accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obliged to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or;
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions, please feel free to ask us. Thank you.

Patient Name: _____

Responsible Party Name (if different) _____

Responsible Party Signature: _____ **Date**: _____