CHRISTEL A. HUMMERT, DMD
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ORTHODONTIC REGISTRATION AND MEDICAL/DENTAL HISTORY FORM **DATE: _____**

Welcome to our office! Please take a few moments to fill out the following information. All of the information will remain strictly confidential.

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____
Birth Date: _____/_____/_____ Age: _____ Sex: ☐M ☐F I Prefer To Be Called: _____
Home Phone #:_____ Cell Phone #: _____ Work #: _____
E-Mail Address: _____Social Security #: _____
Preference for Appointment Confirmation: ☐E-Mail ☐Cell ☐Home ☐Work
Patient's Address: _____ City: _____ State: _____ Zip: _____
Who may we thank for recommending you to Garden State Orthodontics for treatment? _____
Patient's School/ Employer: _____Grade/ Position: _____
Number of Brothers and Sisters: _____ Ages: _____
Other Family Members or Friends Treated Here: _____
Custodial Parent(s) or Guardian(s) (If Applicable): _____
Name of Patient's Dentist: _____ Date Last Seen: _____
Dentist's Address: _____ Dentist Phone #:_____
Reason for Last Dental Visit: _____
Did your dentist recommend orthodontic treatment? ☐ Yes ☐ No Specifically for what? _____
Name of Patient's Physician: _____ Date Last Seen: _____
Reason for Last Physician's Appointment: _____
Person Financially Responsible for this Account: _____

FOR PATIENS UNDER 18 AND/OR FULL TIME STUDENTS:

Mother's Name: _____ Home Phone #: _____ Cell Phone #: _____
Mother's Address:_____ City: _____ State: _____ Zip: _____
Work Phone #: _____ E-Mail: _____
Father's Name: _____ Home Phone #: _____ Cell Phone #:_____
Father's Address: _____ City: _____ State: _____ Zip: _____
Work Phone #: _____ E-Mail: _____
What is patient's favorite: Sport_____Hobby _____ Musical Instrument _____ Candy_____

INSURANCE INFORMATION:

***We must have SS# and Birth Date of Policy Holder(s) to submit your claims.**
Do you have insurance coverage for orthodontic treatment? ☐ Yes ☐ No ☐ I don't know
Primary Policy Holder Name: _____ Insurance Company Name: _____
Group ID # _____ Social Security #: _____ Birth Date: _____/_____/_____
Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse
Secondary Policy Holder Name: _____ Secondary Insurance Company Name:_____
Group ID # _____ Social Security #: _____ Birth Date: _____/_____/_____
Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse

PATIENT PROFILE:

Why do you think orthodontic treatment is necessary – what would you like us to accomplish with orthodontic treatment?

_____
Is the patient concerned about the appearance of his/her smile? ☐ No ☐ Yes Why? _____
Are there any other members of your family that have a similar smile? ☐ No ☐ Yes Who? _____
Has the patient ever had any orthodontic treatment or appliances before? ☐ No ☐ Yes What? _____
Is there anything we should know that would help us better treat the patient? ☐ No ☐ Yes If so, what?
_____

OVER →

MEDICAL AND DENTAL HISTORY:

A thorough and complete medical/dental history is vital to a proper orthodontic evaluation. Now or in the past, has the patient ever had (mark yes, no or dk/u for don't know/understand): **Please answer *EVERY* question to the best of your knowledge.**

☐Yes	☐No	☐dk/u	Birth defects/hereditary problems	☐Yes	☐No	☐dk/u	Hayfever, asthma, sinus trouble
☐Yes	☐No	☐dk/u	Bone fractures, major accidents	☐Yes	☐No	☐dk/u	Tonsil or adenoid conditions
☐Yes	☐No	☐dk/u	Rheumatoid or arthritic problems	☐Yes	☐No	☐dk/u	Substance abuse problems
☐Yes	☐No	☐dk/u	Endocrine or thyroid problems	☐Yes	☐No	☐dk/u	Chew or smoke tobacco
☐Yes	☐No	☐dk/u	Kidney problems	☐Yes	☐No	☐dk/u	Mitral Valve Prolapse
☐Yes	☐No	☐dk/u	Diabetes	☐Yes	☐No	☐dk/u	Do you have osteoporosis, osteopenia
☐Yes	☐No	☐dk/u	Cancer, tumor, radiation, chemotherapy	☐Yes	☐No	☐dk/u	Are you taking IV bisphosphonates
☐Yes	☐No	☐dk/u	Stomach ulcer or hyperacidity	☐Yes	☐No	☐dk/u	Are you taking oral bisphosphonates
☐Yes	☐No	☐dk/u	Polio, mono, tuberculosis, pneumonia	☐Yes	☐No	☐dk/u	Allergy to local anesthetics
☐Yes	☐No	☐dk/u	Problems with immune system	☐Yes	☐No	☐dk/u	Allergy to Aspirin
☐Yes	☐No	☐dk/u	AIDS or HIV positive	☐Yes	☐No	☐dk/u	Allergy to Ibuprofen (Motrin, Advil)
☐Yes	☐No	☐dk/u	Hepatitis, jaundice, or liver problem	☐Yes	☐No	☐dk/u	Allergy to Penicillin or other antibiotics
☐Yes	☐No	☐dk/u	Fainting spells or neurological problem	☐Yes	☐No	☐dk/u	Allergy to Sulfa drugs
☐Yes	☐No	☐dk/u	Seizures or epilepsy	☐Yes	☐No	☐dk/u	Allergy to codeine or other narcotics
☐Yes	☐No	☐dk/u	Mental health disturbance or depression	☐Yes	☐No	☐dk/u	Allergy to metals (jewelry, etc.)
☐Yes	☐No	☐dk/u	Vision, hearing, speech, taste difficulty	☐Yes	☐No	☐dk/u	Allergy to latex
☐Yes	☐No	☐dk/u	Loss of weight recently, poor appetite	☐Yes	☐No	☐dk/u	Allergy to vinyl
☐Yes	☐No	☐dk/u	History of eating disorder	☐Yes	☐No	☐dk/u	Allergy to acrylic
☐Yes	☐No	☐dk/u	Excessive bleeding/ bleeding disorder	☐Yes	☐No	☐dk/u	Allergy to animals (specify):
☐Yes	☐No	☐dk/u	Anemia	☐Yes	☐No	☐dk/u	Allergy to foods (specify):
☐Yes	☐No	☐dk/u	High or low blood pressure	☐Yes	☐No	☐dk/u	Allergy to anything other (specify):
☐Yes	☐No	☐dk/u	Chest pain, shortness of breath	☐Yes	☐No	☐dk/u	Family history of bleeding disorder
☐Yes	☐No	☐dk/u	Cardiovascular problem, stroke	☐Yes	☐No	☐dk/u	Family history of diabetes
☐Yes	☐No	☐dk/u	Heart murmur, heart defects	☐Yes	☐No	☐dk/u	Family history of metabolic problems
☐Yes	☐No	☐dk/u	Rheumatic heart disease	☐Yes	☐No	☐dk/u	Family history of unusual dental problems
☐Yes	☐No	☐dk/u	Skin disorder and/or herpes	☐Yes	☐No	☐dk/u	Family history of severe allergies
☐Yes	☐No	☐dk/u	Frequent head aches, colds, sore throat	☐Yes	☐No	☐dk/u	Family history of jaw size imbalance
☐Yes	☐No	☐dk/u	Eye, ear, nose or throat condition	☐Yes	☐No	☐dk/u	Operations? (Specify):
☐Yes	☐No	☐dk/u	Artificial heart valves	☐Yes	☐No	☐dk/u	Hospitalizations?(Specify):
☐Yes	☐No	☐dk/u	Artificial joints, shunts and/or stents	☐Yes	☐No	☐dk/u	Other physical problems or symptoms:

☐Yes	☐No	☐dk/u	Primary teeth that had to be removed	☐Yes	☐No	☐dk/u	TMD or jaw joint pain or problems
☐Yes	☐No	☐dk/u	"Extra" or supernumerary teeth	☐Yes	☐No	☐dk/u	Thumb or finger sucking habit
☐Yes	☐No	☐dk/u	Missing teeth	☐Yes	☐No	☐dk/u	Tongue thrusting, lip wedging habit
☐Yes	☐No	☐dk/u	Accidents or trauma to the teeth or face	☐Yes	☐No	☐dk/u	Mouth breathing habit
☐Yes	☐No	☐dk/u	Fractured, injured, or damaged teeth	☐Yes	☐No	☐dk/u	Tooth grinding or jaw clenching habit
☐Yes	☐No	☐dk/u	Periodontal disease or "gum" problems	☐Yes	☐No	☐dk/u	Jaw fracture, cysts, or mouth infections

MEDICATIONS: List *ALL* medications, vitamins, supplements and/or herbal medications that are being taken and why:

_____

_____

Please list any other medical conditions and/or allergies:_____

How often does the patient brush his/her teeth? _____ Floss? _____

FOR GIRLS: Has the patient started her monthly periods? ☐ Yes ☐ No If yes, approximately when?_____
Is the patient pregnant? ☐ Yes ☐ No If yes, when is the due date? _____

I have read and understand all of the above questions. I understand that providing incorrect information can be dangerous to my health. I will not hold Dr. Christel A. Hummert and/or Garden State Orthodontics, PA responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history record or medical/dental status, I will promptly inform Dr. Christel A. Hummert and Garden State Orthodontics, PA.

Signed: _____ Date: _____
(Patient or Parent/Guardian)

_____

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HIPAA 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, and ask any questions you may have. We will ask you to sign the back of this form prior to starting any treatment.

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 payers 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 you 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 you 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 an 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; and,
- 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 that if we do so, we will provide you with a copy of the revised Privacy Notice.

(OVER →)

Please note that we are not obligated 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 other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask Dr. Hummert prior to signing. Thank you.

Patient Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____ _____

Signature Printed Name Date

_____ _____

Patient Name Relationship to Patient

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

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 in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditations and licensure).

You have the right to review our office's privacy notice prior to signing this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions. Signature below affirms that I have read and understand the HIPAA Notice of Privacy Practices of Garden State Orthodontics, PA and Dr. Hummert, and that I consent to treatment under those provisions.

_____ _____ _____

Signature Printed Name Date

_____ _____

Patient Name Relationship to Patient