ORTHODONTIST

Dr. Laura C. Sotomayor, DDS, MS

174 Forest Avenue, Locust Valley, New York 11560
516.676.8900 www.smilesetter.com

NEW PATIENT FORM
— CONFIDENTIAL —
(PATIENT UNDER AGE 18)

PATIENT INFORMATION

Name: _____ (Last) _____ (First) _____ (Middle)

Male ☐ Female ☐ Birth Date: ____/____/____ Age: _____ Nickname: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Telephone: _____ (Home) _____ (Cell) E-mail: _____

Patient's School: _____ Patient's Grade: _____

Patient's Hobbies/Sports/Musical Instruments: _____

Names & Ages of Patient's Siblings: _____

Whom may we thank for referring you? _____

PARENT/GUARDIAN INFORMATION (PERSON RESPONSIBLE FOR ACCOUNT)

Name: _____ (Last) _____ (First) _____ (Middle)

Male ☐ Female ☐ Birth Date: ____/____/____ Relationship to Patient: _____

Address: (if different from patient) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Telephone: _____ (Home) _____ (Cell) E-mail: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Telephone: _____

INSURANCE INFORMATION

Orthodontic Coverage? Yes ☐ No ☐ Unsure ☐

Insurance Company Name & Telephone: _____

Subscriber's Name: _____ (Last) _____ (First) _____ (Middle)

Relationship to Patient: _____ Subscriber's Employer: _____

Subscriber's Birth Date: ____/____/____ Subscriber's SSN: _____

Subscriber's ID/Policy Number: _____ Group Number: _____

PATIENT MEDICAL HISTORY

Does patient have any **MEDICAL PROBLEMS/CONDITIONS**? Yes ☐ No ☐

If yes, please specify: _____

Does patient take any prescription or over-the-counter **MEDICATIONS**? Yes ☐ No ☐

If yes, please specify: _____

Does patient have any **ALLERGIES** to medications, metals, acrylics, ceramics, or latex? Yes ☐ No ☐

If yes, please specify: _____

Has **PUBERTY** begun? Yes ☐ No ☐ (Female Patients) Monthly periods begun? Yes ☐ No ☐

PATIENT DENTAL HISTORY

Dentist's Name: _____ Last Dental Visit Date: _____

Dentist's City/Town: _____ Dentist's Telephone: _____

How often does patient brush? _____ Floss? _____

What is the main concern that brings patient to the orthodontist? _____

_____

Now, or in the past, has patient had any of the following (check all that apply):

Orthodontic treatment or evaluation	☐	Thumb, finger or sucking habit	☐
Serious trouble with dental treatment	☐	Abnormal swallowing habit (thrusting)	☐
Periodontal (gum) problems/treatment	☐	Speech problems	☐
Early or late teething	☐	Mouth breathing or snoring habit	☐
Supernumerary or extra teeth	☐	Teeth grinding or jaw clenching/locking	☐
Permanent teeth removed	☐	Jaw pain or ringing in the ears	☐
Chipped or injured teeth	☐	Face muscle pain/soreness near ears	☐
Injuries to face, jaws, or mouth	☐	Difficulty in chewing or jaw opening	☐
Bleeding gums, bad taste or mouth odor	☐	Supplemental fluoride treatment	☐
Teeth sensitive to hot or cold	☐	Concern about spaced/crooked teeth	☐
Root canal treatment	☐	Concern about jaw size discrepancy	☐
Loose, broken or missing fillings	☐	Relative with similar jaw relationship	☐

I understand the above questions and will not hold my orthodontist or any member of her staff responsible for omissions or errors I have made in the completion of this form. I understand it is my responsibility to inform this office about any changes to this history record or patient medical/dental status, and that I should do so at the earliest possible time. Upon proceeding with orthodontic treatment, I authorize payment of applicable insurance benefits to this office.

Parent/Guardian Signature: _____ Date: _____

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PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT TO US.

We use and disclose health information about you for treatment, payment and healthcare operations. Your protected health information (including individually identifiable information such as names, phone numbers, email addresses, home addresses, social security numbers, demographic data, etc.) may be used or disclosed by us in the following respects:

- Internally, to staff members who have a role in providing or coordinating your orthodontic treatment;
- To other healthcare providers (your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you;
- To third party payers (insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) or spouses in order to obtain payment of your account;
- To certifying, licensing and accrediting bodies (the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- To your family members and close friends involved in your treatment;
- To provide you with appointment reminders or information about your treatment or other health-related benefits and services;
- In connection with our healthcare operations, including quality assessment/improvement activities, conducting training programs and evaluating practitioner/provider performance;
- When we are required to do so by law;
- To appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes, to the extent necessary to avert a serious threat to your health/safety or the health/safety of others;
- To military authorities or Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose protected health information to correctional institution or law enforcement officials having lawful custody under certain circumstances.

Under the new privacy rules, you have the right to:

- Receive a paper copy of this Privacy Notice on request;
- Give us written authorization to disclose your health information to anyone for any purpose. Such authorizations may be revoked in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect;
- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information (for example, if you prefer communication via your mobile telephone rather than a residential telephone);
- Obtain and inspect copies of your protected health information upon written request (we may charge you a reasonable cost-based fee for such copies). You may ask that we provide copies in a format other than photocopies — we will use the format you request unless we cannot practicably do so;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests;
- Submit inquiries or complaints regarding any violation by us of your privacy rights to Dr. Sotomayor (our Privacy Contact Person) at our office address or the United States Secretary of Health and Human Services (must be filed within 180 days of the violation).

We have the following duties under the new privacy rules:

- By law, to maintain the privacy of protected health information and 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 currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new 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.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- 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 Privacy Notice, please direct them to Dr. Sotomayor, our Privacy Contact Person.

PATIENT ACKNOWLEDGMENT OF PRIVACY NOTICE

I hereby acknowledge that I have received, reviewed and understand this Privacy Notice.

Patient Name: _____ _____ _____
Last First Middle

Signature of Patient/Parent/Guardian: _____

Relationship to Patient: _____ Date: _____

AUTHORIZATION FOR E-MAIL AND/OR TEXT COMMUNICATION

We offer the option of e-mail and/or text communication for administrative (e.g. appointment reminders) and treatment-related purposes. Our office will use reasonable means to protect the security and confidentiality of information sent and received via e-mail and/or text. However, electronic transmission of information cannot be guaranteed secure or error-free; its confidentiality may be vulnerable to access by unauthorized third parties.

By completing/signing this authorization, you consent to e-mail and/or text communication with us and fully accept any associated risks, including lost, intercepted, misdirected, corrupted or otherwise altered messages. Authorization can be revoked in writing at any time. *You will always be able to communicate with us by phone and postal mail, regardless of whether you opt to communicate with us via e-mail and/or text.*

Signature of Patient/Parent/Guardian: _____

Relationship to Patient: _____ Date: _____

Authorized E-mail Address: _____

Authorized Cell Phone Number for Text: _____