



Practice Limited to Orthodontics

264 Union Avenue  
Holbrook, NY 11741  
Phone: (631) 588-5600  
www.NYBraceTown.com

**Patient Information**

Patient's Name: \_\_\_\_\_  Male  Female

\_\_\_\_\_ First Middle Last

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ Street Town State Zip

If Patient is a minor, give parent's/guardian's name(s): \_\_\_\_\_

Names/Ages of brothers and sisters: \_\_\_\_\_

**Responsible Party Information**

Name: \_\_\_\_\_  Married  Divorced  Single  
\_\_\_\_\_ First Middle Last Marital Status

Custodial Parent:  Mother  Father  Both E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ Street Town State Zip

How long at this address? \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Previous Address (if less then 3 yrs.) \_\_\_\_\_  
\_\_\_\_\_ Street Town State Zip

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
\_\_\_\_\_ First Middle Last

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

**Dental Insurance Information**

Primary Secondary

Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

SS# of Policy Holder: \_\_\_\_\_ SS# of Policy Holder: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Address: \_\_\_\_\_

Insurance Group/Policy#: \_\_\_\_\_ Insurance Group/Policy#: \_\_\_\_\_

- I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to Bracetown Orthodontics of the insurance benefits otherwise payable to me.
- I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
- I certify that the above information is complete and true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Patient's Medical/Dental History**

**Patient's Dentist:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**Town** \_\_\_\_\_ **Phone #:** (\_\_\_\_) \_\_\_\_\_ **Last Visit:** \_\_\_\_\_

What is patient's/parent's primary concern: \_\_\_\_\_  
\_\_\_\_\_

**Patient's Physician:** \_\_\_\_\_ **Phone#:** (\_\_\_\_) \_\_\_\_\_ **Last Visit:** \_\_\_\_\_  
Is patient presently being treated by a physician? Yes No **Why?:** \_\_\_\_\_

Has the patient's tonsils and adenoids been removed? Yes No Is child adopted? Yes No  
Has the patient ever had an unusual reaction to any drug? Yes No Is child aware of adoption? Yes No  
Does patient have a speech problem, if so are they receiving therapy? Yes No

- Has the patient any of the following?
- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Latex Allergy                 |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Breathing Problems          | <input type="checkbox"/> Problems Opening/Closing | <input type="checkbox"/> Metal Allergy                 |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Frequent Colds              | <input type="checkbox"/> Chewing Problems         | <input type="checkbox"/> Seasonal Allergy              |
| <input type="checkbox"/> Pre Medication Required | <input type="checkbox"/> Sinus Problems              | <input type="checkbox"/> Jaw Popping              | <input type="checkbox"/> Other Allergy:<br>List: _____ |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cold Sores                  | <input type="checkbox"/> Grinding/Clenching       | _____  |
| <input type="checkbox"/> Bleeding Problems       | <input type="checkbox"/> ADD/ADHD                    | <input type="checkbox"/> Concussion               | _____  |
| <input type="checkbox"/> Gum Problems            | <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Injury to Teeth/Jaws     | _____  |
| <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Thyroid/Hormonal Imbalance  | <input type="checkbox"/> Severe Headaches         | _____  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Lip Biting                  | <input type="checkbox"/> Facial Pain              | <input type="checkbox"/> Major Surgery                 |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Nail Biting                 | <input type="checkbox"/> Any TMJ History          | _____  |
| <input type="checkbox"/> Convulsions/Seizures    | <input type="checkbox"/> Tongue Thrusting            | <input type="checkbox"/> Nervous Disorder         | _____  |
| <input type="checkbox"/> Immune Deficiency       | <input type="checkbox"/> Presently Suck Thumb/Finger | <input type="checkbox"/> Hearing Problem          | _____  |
| <input type="checkbox"/> Smoke Cigarettes/Cigars |  |   |  |

Has Patient ever had orthodontic treatment or worn a retainer? Yes No  
Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: \_\_\_\_\_  
If Female: Menstruating? Yes No Date of First Period: \_\_\_/\_\_\_/\_\_\_  
If Male: Voice Change? Yes No Date Started: \_\_\_/\_\_\_/\_\_\_ Shaving? Yes No Date Started: \_\_\_/\_\_\_/\_\_\_

Names of Daily Medications? \_\_\_\_\_  
Is there any other information about the patient's health we should know? \_\_\_\_\_  
\_\_\_\_\_

**Whom may we thank for referring you to our office?**  
Please circle all that apply:  
My Dentist    Staff Member at My Dentist Office    Selected Doctor from Insurance Provider List  
Google    Invisalign Website    Yellow Page Ad    Newspaper Ad in: \_\_\_\_\_  
My Friend/Relative Referred Me (list name(s)): \_\_\_\_\_  
\_\_\_\_\_  
Other (please specify): \_\_\_\_\_  
\_\_\_\_\_

**Signature (Parent's if minor):** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Review by Doctor:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

## PRIVACY NOTICE

### 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 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 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.

#### **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 for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

## PATIENT ACKNOWLEDGMENT

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

\_\_\_\_\_

Patient

\_\_\_\_\_

Date