PATIENT REGISTRATION

*Please complete all fields.

Patient Name: _____ Nickname: _____ DOB: _____ ❑M ❑F
Last First Middle

Social Security # _____ If under 18, School _____ Grade _____

Has the patient had previous orthodontic treatment? ❑YES ❑NO If yes, by whom _____ and when _____

Has anyone else in your family sought orthodontic treatment in our office? ❑YES ❑NO If yes, name _____

SELF (if over 18) or PARENT/GUARDIAN

Name: _____
Last First Middle

Relationship to Patient _____

Social Security #: _____ DOB _____

Phone numbers: _____ C H W

Phone numbers: _____ C H W

Phone numbers: _____ C H W

Mobile carrier (for text reminders): _____

Email address _____

Home Address: _____

_____

City: _____ State: _____ Zip: _____

Employer _____

Are Parents Divorced or Separated? ❑YES ❑NO

Who has custody of the patient? ❑Mother ❑Father ❑Joint

SECONDARY RESPONSIBLE PARTY

Name: _____
Last First Middle

Relationship to Patient _____

Social Security #: _____ DOB _____

Phone numbers: _____ C H W

Phone numbers: _____ C H W

Phone numbers: _____ C H W

Mobile carrier (for text reminders): _____

Email address _____

Home Address: _____

_____

City: _____ State: _____ Zip: _____

Employer _____

INSURANCE INFORMATION - *Please give your insurance card to our Scheduling Coordinator so that we may obtain a copy.

Insured's Name _____

DOB _____ Insured's Social # _____

Insured's Employer/Group Name _____

Insurance Company _____

Group # _____ ID Number _____

Insurance Co Address _____

_____

PATIENT'S DENTAL HISTORY

Name of Dentist _____ Date of last dental checkup _____

What are your concerns about your smile? _____

Do you have any concerns about facial esthetics, such as, but not limited to, a retruded or crooked chin? ❑YES ❑NO

If Yes, please explain: _____

Would you like to be informed if corrective jaw surgery is necessary to achieve an ideal result? ❑YES ❑NO

Has the patient had any of the following:

Finger, thumb or lip habit ❑YES ❑NO How severe _____ How long _____ When (night only, etc.) _____

Periodontal disease (pyorrhea) ❑YES ❑NO If yes, who is treating the condition? _____

Injury to face or tooth or root canal treatment? ❑YES ❑NO Explain _____

Clicking or pain in the jaw joint? ❑YES ❑NO

Headaches, dizziness or ringing in the ears? ❑YES ❑NO

Limited opening or locking of the jaw? ❑YES ❑NO

Speech problems? ❑YES ❑NO

Patient's attitude toward brushing? ❑Good ❑Fair ❑Poor

Cooperation with orthodontic treatment? ❑Good ❑Fair ❑ Poor

Patient's attitude toward braces? ❑Good ❑Fair ❑Poor

Patient's attitude toward dentistry? ❑Good ❑Fair ❑Poor

PATIENTS MEDICAL HISTORY

Physicians Name _____ Date of last physical _____

Patient's General Health ❑Good ❑Fair ❑Poor

Has the patient had any of the following:

Heart Murmur ❑YES ❑NO If yes, does the patient require medication for dental appointments? ❑YES ❑NO

Rheumatic Fever ❑YES ❑NO

Diabetes ❑YES ❑NO

Heart Trouble ❑YES ❑NO

AIDS, Herpes or HIV ❑YES ❑NO

Emotion Problems ❑YES ❑NO

Asthma ❑YES ❑NO

Epilepsy ❑YES ❑NO

Blood Transfusion ❑YES ❑NO

Hepatitis ❑YES ❑NO

Hyperactivity ❑YES ❑NO

Breathing Disorder/OSA ❑YES ❑NO

Is the patient taking any medication? ❑YES ❑NO

Please list: _____

Are there any allergies or drug sensitivities? ❑YES ❑NO

Please list: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

By entering my full name in the spaces below, I hereby acknowledge that:

I authorize the orthodontic offices of Johnson Orthodontics to release any information for _____
(Patient Name)

regarding the dental history and/or treatment to any dentist, dental specialist, etc. for the purpose of verifying, evaluating or treating the aforementioned patient. I understand that, where appropriate, credit bureau reports may be obtained.

Signature _____ Date _____
(Parent's signature, if minor)

HOW DID YOU HEAR ABOUT US?

Please take a moment to let us know how you heard about our office. Please check the main reason you selected our office. Thank you!

- ☐ Dentist/Hygienist
- ☐ Family Member/Sibling
- ☐ Other – Please State _____
- ☐ Internet
- ☐ Friends/co-workers
- ☐ School/Teacher
- ☐ Building sign

JOHNSON ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

By entering my full name in the spaces below, I hereby acknowledge that:

I, _____, have received a copy of this office's notice of
(Parent or guardian if patient is under 18 years of age)

privacy practices (see back) for _____.
(Patient Name)

Please sign _____ **Date** _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Parent/Guardian unavailable at appointments to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

JOHNSON ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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 IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare options. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by our authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to the authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, emails, text messages, postcards, or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will change you $0.75 each page and $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web Site or by electronic means (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact: Diane Grigg •Telephone: 540-989-5621 •Email: diane@emjortho.com •Address: 3231 Electric Rd. Roanoke, VA 24018 • Fax: 540-989-8080

PERMISSION TO OBTAIN ORTHODONTIC RECORDS

In order to complete a comprehensive examination, Dr. Johnson is requesting your permission to obtain the following:

Extraoral (Facial) and Intraoral (Inside your mouth) Photographs

Radiographs (X-rays), which can include:

Panoramic Radiograph

Cephalometric Radiograph

CBCT (3-D Radiograph) – this is needed for unique situations, such as but not limited to impactions, extra teeth or extreme malposition of teeth.

Digital Impressions (no radiation required)

Every patient's needs are unique. Only those images and radiographs that are absolutely necessary for your care will be obtained. We follow the ALARA (As Low As Reasonably Achievable) principle of radiation exposure.

Should Dr. Johnson determine a CBCT Radiograph (see above) is NECESSARY for comprehensive diagnosis and treatment planning, **a fee of $100 will be charged**. Otherwise, all of our Orthodontic Records are complimentary.

By entering my full name in the spaces below, I hereby acknowledge that:

I, _____, give permission for Johnson Orthodontics to obtain the above records for _____ (please write "Myself" if you are at least 18 years old.

Patient/Parent/Guardian Signature:_____

Date: _____

Release Form for Media Usage

By entering my full name in the spaces below, I hereby acknowledge that:

I, the undersigned, a Patient of Johnson Orthodontics (the "Practice"), do hereby acknowledge that the Practice has a legitimate interest in creating a photographic and/or audiovisual record of me, that the Practice desires to use such photographs and audiovisual recordings in various publications and promotional materials, including printed media, and that my image and/or voice, may be the subject of and/or included in such photographs and/or audiovisual recordings by virtue of my participation in the Practice's promotional activities.

I do hereby consent and agree that the Practice, its employees, or agents have the right to use photographs, videotape, or digital recordings of me and to use these in any and all forms of media and exclusively for the purpose of the Practice that has provided me with dental or orthodontic services. I further consent that my first name only may be used therein or by descriptive text or commentary.

Accordingly, I hereby grant to the Practice the right to photograph me and to record my image and/or voice by any means now known or hereinafter devised, in connection with the Practice's promotional activities, together with the perpetual but non-exclusive right to use, duplicate, and publish such photographs, and any such recordings of my image and/or voice, to edit at the Practice's discretion, to identify me by first name only in connection with such photographs and/or recordings, or refrain from doing so, and to distribute same for the purpose of promoting the Practice and its activities.

I hereby waive the opportunity or right to inspect or approve the proofs, negatives, tests, finished films, video, sound recordings and/or photographs or the uses to which the same may be put. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I have read and understand the contents of this release and am executing same of my own free will. If I am under 18 years of age, my parent and/or legal guardian has entered their full name below and by so doing **ACKNOWLEDGES** and agrees to the terms of this agreement, both individually, and on my behalf.

_____ _____

Signature Date

If you wish to **DECLINE** this consent, please indicate so by signing below.

_____ _____

Signature Date

Release of Information to Person(s) Other Than Parent/Legal Guardian

Please consider signing the following authorization if someone else (family member, sitter, family friend, etc.) will be bringing the patient to appointments with our office.

Patient's Full Name:

_____

Name of person(s) being given permission/authorization:

_____

_____

_____

By entering my full name in the spaces below, I hereby acknowledge that:

I give my permission/authorization to the above-named person(s) to:

(Please check all that apply)

- ☐ **discuss initial and ongoing treatment plans**
- ☐ **make treatment decisions**
- ☐ **discuss financial arrangements and accounts**
- ☐ **be allowed to receive applicable financial ledgers**

I represent that I have read and understand this agreement, and am the parent or legal guardian of the aforementioned patient. This permission will remain in effect during the duration of the treatment and/or financial obligation with Johnson Orthodontics or until I revoke said authorization. I understand that I have the right to revoke this authorization at any time by providing written notice to Johnson Orthodontics.

_____ _____

Signature Date