Great Lakes
ORTHODONTICS

ADULT Patient Registration

WELCOME TO OUR OFFICE!

TODAY'S DATE:______/______/______
MM DD YY

ABOUT YOU

NAME: ________________________________
LAST FIRST MI

PREFERRED NAME:__________ GENDER: ☐ M ☐ F

ADDRESS:______________________________
____
CITY STATE ZIP CODE

HOME PHONE: ___________________________
WORK PHONE: ___________________________
CELL PHONE: ____________________________
EMAIL:__________________________________

PREFERRED APPOINTMENT REMINDER METHOD?
☐**TEXT** ☐**EMAIL** ☐**BOTH**

MARITAL STATUS: ☐ **S** ☐ **M** ☐ **W** ☐ **D**

BIRTHDAY: ____/____/____

SSN:____________________________________

EMERGENCY CONTACT INFORMATION

NAME: ____________RELATION:____________
PHONE: ________________________________
EMAIL:__________________________________

SPOUSE INFORMATION (IF DIFFERENT)

HIS/HER NAME: ___________________________
PHONE: ________________________________
EMAIL:__________________________________

DENTIST INFORMATION

DENTIST NAME: __________________________
ADDRESS:_______________________________
PHONE NUMBER:__________________________
DATE OF LAST EXAM/CLEANING:_____________

ANY OUTSTANDING DENTAL WORK?: ☐ **YES** ☐ **NO**
IF YES, PLEASE EXPLAIN: ____________________
____
____

WERE YOU REFERRED TO US?: ☐ **YES** ☐ **NO**
IF YES, PLEASE EXPLAIN: ____________________
____
____

PREVIOUS ORTHODONTIC TREATMENT:
☐ **YES** ☐ **NO**
IF YES, PLEASE EXPLAIN: ____________________
____
____

EMPLOYMENT

EMPLOYER:______________________________
POSITION/OCCUPATION:___________________
HOW LONG THERE: _______________________

DENTAL INSURANCE INFORMATION

EMPLOYER:____________POSITION:________
INS. COMP. NAME:________________________
INSURED NAME:__________________________
INSURED BIRTHDAY:______________________
INSURED ID#: ___________________________
GROUP #: ______________________________
INS PHONE#: ____________________________
ORTHO COVERAGE KNOWN?:
☐ **YES** ☐ **NO** ☐ **UNKNOWN**
IF SO, BENEFIT AMOUNT:__________________

2ND DENTAL INSURANCE INFORMATION

EMPLOYER:____________POSITION:________
INS. COMP. NAME:________________________
INSURED NAME:__________________________
INSURED BIRTHDAY:______________________
INSURED ID#: ___________________________
GROUP #: ______________________________
INS PHONE#: ____________________________
ORTHO COVERAGE KNOWN?:
☐ **YES** ☐ **NO** ☐ **UNKNOWN**
IF SO, BENEFIT AMOUNT:__________________

Great Lakes ORTHODONTICS

ADULT Patient Registration

WELCOME TO OUR OFFICE!

PATIENT NAME:_____________________

MEDICAL HISTORY

Patient's Physician:__________________________ Phone: ________________ Last Exam: _________

Does your child have/had:	Yes	No		Yes	No
Birth Defect	☐	☐	Eye Disorder	☐	☐
Cleft Lip/Palate	☐	☐	Hearing Problems	☐	☐
Speech Difficulty	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Cystic Fibrosis	☐	☐
Blood Transfusion	☐	☐	Tuberculosis	☐	☐
Emotional Disorder	☐	☐	Developmental Disorder/Delay	☐	☐
Diabetes	☐	☐	Thyroid or Endocrine Disorder	☐	☐
Heart Disease	☐	☐	Heart Murmur or Heart Condition	☐	☐
Hepatitis or Liver Disease	☐	☐	Rheumatic Fever	☐	☐
Neurological Disorder	☐	☐	Epilepsy or Seizures	☐	☐
Anemia	☐	☐	Bleeding Disorder	☐	☐
Injury to Face/Teeth/Gums	☐	☐	Tonsil/Adenoid Surgery	☐	☐
Cold Sores	☐	☐	HIV Positive	☐	☐
Cancer	☐	☐	Advised to take antibiotics prior to dental visit	☐	☐

If yes, please explain: ____
____

List any conditions not mentioned: ____

List any known allergies (medications, latex, etc): ____________________________

List all current medications: ____

Has you taken any oral or IV bisphosphonate drugs (Boniva, Fosamax, etc): ___________

DENTAL AND ORTHODONTIC HISTORY

Chief Complaint/Concern: ____

Previous Orthodontic Treatment: ☐ **YES** ☐ **NO** If yes, explain: _______________________

Any missing teeth: ☐ **YES** ☐ **NO** ☐ **UNSURE** If yes, explain: _______________________

Any jaw joint pain/discomfort: ☐ **YES** ☐ **NO** If yes, explain: _______________________

Any history of dental trauma: ☐ **YES** ☐ **NO** If yes, explain: _______________________

Do you grind your teeth at night: ☐ **YES** ☐ **NO** If yes, do you wear a bite splint: ☐ **YES** ☐ **NO**

How often do you brush: ________________ How often do you floss: ________________

____ Date:____________________

Patient Signature

Great Lakes ORTHODONTICS

HIPAA CONSENT FORM

This consent form allows Great Lakes Orthodontics to use and disclose information about me protected under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).** This information may be used or disclosed to carry out treatment, payment, or health care operations. I acknowledge that Great Lakes Orthodontics (GLO) has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. I understand that I have the right to review and I have reviewed the Notice of Privacy Practices prior to signing this document. I understand that the terms of this document may change and that I may obtain revised notices by contacting the Privacy Officer.

I UNDERSTAND:

- My PHI means health information, including my demographic information, collected from me and created or received by my doctor, another health care provider, a health plan, or a healthcare clearinghouse. This Protected Health Information (PHI) relates to my physical or mental health and identifies me or provides reasonable basis to believe the information may identify me.
- I understand that I have the right to request how protected health information is used or disclosed to carry out treatment, payment, and health care operations and must be provided to me in writing.
- I understand that I may request restrictions of my PHI, but Great Lakes Orthodontics is not required to agree to these restrictions if they interfere with reasonable delivery of care. However, if Great Lakes Orthodontics agrees to a restriction that I may request, the restriction is binding on Great Lakes Orthodontics.
- I understand that I have the right, at any time, to revoke this consent, provided that I do so in writing, but Great Lakes Orthodontics may still use information to complete any actions that it began prior to my revoking consent and which rely on my PHI. I understand that Great Lakes Orthodontics may refuse service if I revoke this consent.

I AUTHORIZE:

- Great Lakes Orthodontics to leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my upcoming appointments.
- Great Lakes Orthodontics to disclose my health information to any person(s) who may accompany me to my appointment and are present with me during my visit with the orthodontist and staff.
- Great Lakes Orthodontics to communicate with me using unsecured email and mobile messaging to transmit information related to scheduling of appointments and information related to billing and payment.
- Great Lakes Orthodontics to communicate or consult with other health professionals or staff who may be involved in the delivery of my health or dental care.
- Great Lakes Orthodontics to disclose my PHI to my emergency contact and the following persons:

Name	Relationship to Patient	Phone Number

By my signature below, I affirm the above information:

Patient Name (Please Print) ____

Signature of Patient/Parent ______________________________ **Date:** __________

Great Lakes
ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical/dental Information. We make a record of the dental core we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality dental care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical/dental Information. It also describes your rights and our legal obligations with respect to your medical/ dental information. If you have any questions about this Notice, please contact our office.

How We May Use or Disclose Your Health Information

This practice collects health information about you and stores it in a paper or electronic health record. This is your dental record. The dental record Is the property of this dental practice, but the information in the dental record belongs to you. The law permits us to use or disclose your health Information for the following purposes:

1. Treatment. We use medical/dental information about you to provide your dental care. We disclose medical/dental information to our employees and others who are involved in providing the care you need. For example, we may share your medical/dental information with other dentists or other health care providers who will provide services that we do not provide. We may also disclose medical/dental Information to members of your family or others who can help you when you are sick or Injured, or after you die.
2. Payment. We use and disclose medical/dental information about you to obtain payment for the services we provide . For example, we give your health plan the Information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical/dental Information about you to operate this dental practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your dental plan to authorize services or referrals . We may also use and disclose this information as necessary for dental reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with other health care providers, health care clearing houses or dental plans that have a relationship with you.
4. Appointment Reminders. We may use and disclose medical/dental Information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical/dental Information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location or your general condition. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures; although we may disclose this information in a disaster even over your objection If we believe it Is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. We will not use or disclose your medical/dental information for marketing purposes or accept any payment for other marketing communications without your prior written authorization . The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. Sale of Health Information. We will not sell your health information without your prior written authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or Infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and Imminent threat to the health or safety of a particular person or the general public.

Great Lakes ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

15. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we may be required make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
16. Change of Ownership. In the event that this dental practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another dentist or dental group.
17. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e- mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

When This Dental Practice May Not Use or Disclose Your Health Information
This practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this dental practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosure of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical/dental information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing . We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this dental practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the Information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may in turn prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information .
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this dental practice.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

Complaints
Complaints about this Notice of Privacy Practices or how this dental practice handles your health information should be directed to our office. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Voice Phone (8001 368-1019
FAX (312) 886-1807
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
You will not be penalized in any way for filing a complaint.