Maine Orthodontics
SHUMAN · RAZZAGHI

207-797-5577 www.maineorthodontics.com

ADULT PATIENT REGISTRATION FORM

Name _____ Identifies as: Male Female Non-Binary
(Last / First / Middle Initial / Nickname)

Address _____
(Street / City / Zip Code)

Residential Telephone _____ Marital Status _____ Date of Birth ____/____/____ Age _____
(MO / DAY / YR)

Occupation _____ Social Security # _____

Email _____ Cell Phone _____

Employer _____ Business Telephone _____

Spouse's Name _____ Social Security # _____

Employer _____ Business Telephone _____ Cell Phone _____

Person Responsible for Account _____

****Insurance Information:** If insurance is to be processed, please fill out the attached form.

MEDICAL HISTORY

Name of Physician _____ Date of last visit _____

Are you currently under a physician's care? ☐ Yes ☐ No

if **yes**, reason _____

Are you currently taking any medications? ☐ Yes ☐ No

if **yes**, what _____

Have you ever been hospitalized or had any serious illnesses? ☐ Yes ☐ No

if **yes**, why _____

Have you ever had a bad reaction to a drug or food? ☐ Yes ☐ No

if **yes**, which one(s)? _____

Have tonsils or adenoids been removed? ☐ Yes ☐ No

if **yes**, when _____

Women: Are you pregnant? ☐ Yes ☐ No

Do you have a history of (Please check any boxes which apply)

- ☐ Rheumatic Fever
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Swollen Glands
- ☐ Sinus Problems
- ☐ Bone Disorders or Arthritis
- ☐ Stomach Disorders
- ☐ Growth Problems
- ☐ Kidney Disorder
- ☐ High Blood Pressure
- ☐ Allergies/Hayfever
- ☐ Heart Disorder
- ☐ Heart Murmur
- ☐ AIDS or ARC
- ☐ Respiratory Problems or Tuberculosis
- ☐ Blood Disorder
- ☐ Frequent Headaches
- ☐ Artificial Joints/Valves/Pacemaker
- ☐ Recent Weight Loss or Night Sweats
- ☐ Hepatitis or Yellow Jaundice
- ☐ Abnormal or Prolonged Bleeding
- ☐ Diabetes
- ☐ Fainting, Dizziness or Seizures
- ☐ Cancer
- ☐ Mental Health Problems
- ☐ **NONE OF THE ABOVE**

Any other medical problems we should be aware of? ☐ Yes ☐ No

If yes, what _____

_____

_____

- see next page -

DENTAL HISTORY

Explain the nature of the problem in your own terms _____

_____

Name of Dentist?_____ Were you referred by your dentist? ☐ Yes ☐ No

if **no**, how did you hear about our office? _____

Date of last visit to your dentist_____ Date of last cleaning _____

Have you seen an orthodontist in the past? ..... ☐ Yes ☐ No

if **yes**, who and when_____

Have you ever been told you have periodontal disease? ..... ☐ Yes ☐ No

How often do you use dental floss: ☐ Daily ☐ Weekly ☐ Infrequently

Do you have a history of (Please check any boxes which apply)

- ☐ Bleeding Gums
- ☐ Jaw Pain upon Awakening
- ☐ Injury to Face, Neck, Mouth or Teeth
- ☐ Uncomfortable Bite
- ☐ Changing Tooth Positions
- ☐ Noises of Jaw Joints
- ☐ Jaw Joint getting "Stuck," "Locked," or "Going Out
- ☐ Clenching or Grinding of Teeth
- ☐ Pain when Yawning or upon Wide Opening
- ☐ Pain in or about Ears, Temples or Cheeks
- ☐ Treatment for a Jaw Joint Problem TMJ
- ☐ **NONE OF THE ABOVE**

Are there any other dental problems we should be aware of? ..... ☐ Yes ☐ No

if **yes**, what? _____

Has anyone in your family been treated in our office? ☐ Yes ☐ No If yes, who? _____

_____

_____

The above information is true to the best of my knowledge. I understand that all fees are due when services are rendered, unless prior arrangements have been made.

Signature _____ Date _____

ORTHODONTIC INSURANCE

Orthodontic insurance is different than regular dental coverage. Most often orthodontics benefits are a separate coverage that has a maximum lifetime amount. Below is an informational form with the correct questions to ask regarding your individual orthodontic coverage and a place to record the information.

Patient's Name: _____ Patient's DOB: _____

Insurance Company Name: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____ State: _____ Zip: _____

Insurance ID #: _____ Group #: _____

Employer Name: _____ Subscriber Name: _____

Subscriber Relationship to Patient: _____ Subscriber DOB: _____

After giving the above information to your insurance representative ask:

Do I have orthodontic coverage? Yes _____ No____

If yes: Lifetime Maximum? _____ Percentage Paid? _____ Age Limit? _____ Deductible? _____

Waiting Period? _____ Prior Benefits Used? _____ Effective Date of Policy? _____

How are benefits paid? _____

Name of Representative you spoke with: _____ Date Called: _____

Please note that most insurance companies to not pay the full benefit maximum in one lump sum at the start of treatment. Benefits will be paid monthly or quarterly over 12-24 months. Please do not cancel your policy before the full benefit has been paid. If your insurance plan switches during treatment, please provide our office with update insurance information: (207) 797-5577 or info@maineorthodontics.com.

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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 4 / 15 / 03, 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 operations. 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 and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and 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 your 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 locating) 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 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 of 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 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 of 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, 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 charge you $0.60 for each page, $30 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 mail (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 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 with the U.S. Department of Health and Human Services.

Contact Officer: J. B. Shuman, D.M.D., M.S. Setareh Razzaghi, D.D.S., M.S.

Telephone: (207)797-5577

E-mail: info@maineorthodontics.com

Address: 1321 Washington Avenue, Portland, ME 04103

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____