



STEGEMANN · SHUMAN · RAZZAGHI

207-797-5577 www.maineorthodontics.com

**CHILD PATIENT REGISTRATION FORM**

Name \_\_\_\_\_  
Last First Middle Initial Nickname

Patient's Address \_\_\_\_\_  
Street City State Zip Code

Male  Female

Patient Date of Birth \_\_\_\_\_  
MO DAY YR

Age \_\_\_\_\_

**Parent/Guardian**

Name \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_

Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

**Parent/Guardian**

Name \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_

Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

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

**GENERAL APPRAISAL**

1. Explain the nature of the problem in your terms \_\_\_\_\_

2. Does Patient's problem most resemble  Father  Mother  Adopted

3. Are you aware that success of orthodontic treatment depends on cooperation?  Yes  No

4. Will patient cooperation be:  Excellent  Good  Fair  Poor  Indifferent

5. Are you aware that some of your child's orthodontic appointments will infringe on school time?  Yes  No

6. Musical instruments played by Patient \_\_\_\_\_

7. Sports played by Patient \_\_\_\_\_

8. School Patient attends and grade \_\_\_\_\_

9. Has anyone in your family been treated in our office?  Yes  No If yes, who? \_\_\_\_\_

10. Siblings Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

## MEDICAL HISTORY

Name of Physician or Pediatrician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Is Patient currently under a physician's care? .....  Yes  No  
if **yes**, reason \_\_\_\_\_

Is Patient currently taking any medication(s)? .....  Yes  No  
if **yes**, what \_\_\_\_\_

Has Patient ever been hospitalized or had any serious illnesses? .....  Yes  No  
if **yes**, why \_\_\_\_\_

Has Patient 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 \_\_\_\_\_

Onset of puberty: Boys: Has voice changed?  Yes  No If yes, at what age? \_\_\_\_\_

Girls: Has menstruation begun?  Yes  No If yes, at what age? \_\_\_\_\_

Does Patient have a tendency of colds? \_\_\_\_\_ sore throats? \_\_\_\_\_ ear infections? \_\_\_\_\_

Does patient have a history of (Please check any boxes which apply)

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

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

If yes, what \_\_\_\_\_

## DENTAL HISTORY

Name of Dentist \_\_\_\_\_ Were you referred by your dentist?  Yes  No  
if **no**, how did you hear about our office? \_\_\_\_\_

Date of last dental exam \_\_\_\_\_

Has Patient seen an orthodontist in the past? .....  Yes  No  
if **yes**, who and when \_\_\_\_\_

Has the Patient ever been told he or she has periodontal or gum disease? .....  Yes  No

How often does the patient use dental floss?  Daily  Weekly  Infrequently  Never

Does Patient normally have trouble breathing through his/her nose? .....  Yes  No

Does Patient have a history of speech problems? .....  Yes  No

Does Patient have a history of (Please check any boxes which apply)

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

Are there any other dental problems we should be aware of? .....  Yes  No  
if **yes**, what? \_\_\_\_\_

**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.**

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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## NOTICE OF PRIVACY PRACTICES

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**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.**

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### **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.

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### **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).

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#### 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.

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#### 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: T.A. Stegemann, D.M.D., M.S. J.B. Shuman, D.M.D., M.S.

Telephone: 207-797-5577

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: 1321 Washington Avenue

Portland, Maine 04103

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement\*

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_