ASHTON&HUDGINS ORTHODONTICS

WELCOME TO ASHTON & HUDGINS OFFICE

Patient Name: _____Preferred Name: _____Age: _____Grade: _____

Who is with the patient today? _____ Relationship: _____

If the patient is a child: Patient lives with: _____

Custodial Parent is: _____

General Dentist Name is: _____Date of last check up? _____

How did you hear about us?

☐ Dentist/Hygienist _____ ☐ Friend_____

☐ Relative _____ ☐ Other _____

Have other family members been treated in our office? ☐ Yes ☐ No

If yes, who? _____

What treatment options are you most interested in?

☐ Metal Braces
-silver, gold, colors, no colors or shapes

☐ Clear Braces

☐ Invisalign

☐ Retainers

☐ Sleep Apnea/Snoring

☐ Mouthguard/Nightguard

What type of payment options would you prefer?

☐ Payment in Full (with discount)

☐ Affordable Monthly Payments (no interest)
*based on credit history

☐ Care Credit (outside financing)

☐ Not sure

Do you have insurance or flex plan benefits you would like for us to confirm?

☐ Yes ☐ No

Is there anyone else who is going to be involved in the decision to start treatment?

☐ Yes ☐ No

If yes, who? _____

***AUTHORIZATION AND RELEASE:** I agree to be responsible for payment of all charges which are incidental to the care and treatment of the above named patient with my prior consent. I authorize Dr. Joseph Hudgins to release any information acquired in the course of my examination or treatment to third party payers and/or health practitioners. I understand that if I finance orthodontic treatment, I give my consent to have my credit report checked. I also certify the above information is correct.

Signature: _____**Date:**_____

OVER

What is your chief concern?

_____

_____

Have you had another orthodontic consultation?

☐ Yes_____ ☐ No

On a scale of 1 to 5, with 5 being ready to start – how ready are you to start Orthodontic treatment?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

Health History

☐ **Yes** ☐ **No** **Do you have allergies? If yes, Type: _____ Medication: _____**

☐ **Yes** ☐ **No** **Do you breathe through your mouth, or snore when you sleep? Have your tonsils or adenoids been removed? _____**

☐ **Yes** ☐ **No** **Have you ever tested positive for HIV, or ever been diagnosed with hepatitis? _____**

☐ **Yes** ☐ **No** **Have you ever had a thumb, finger or tongue sucking habit? If so, how long? _____ Speech Therapy? _____**

☐ **Yes** ☐ **No** **Do you have, or have you had, any symptoms associated with your temporomandibular joints (TMJ), such as clicking in jaws, headaches, locking of jaws, clenching or grinding? Please explain:**

_____

_____

☐ **Yes** ☐ **No** **Are you currently under medical care for any reason? If yes, what is the condition? _____**

_____

☐ **Yes** ☐ **No** **Do you have any sensitivities or allergies to any metals, such as nickel, copper or titanium? _____**

Describe any accidents or blows to the mouth or chin you have experienced: _____

_____

Please sign for permission:

☐ Permission to take x-rays, photos for chart

☐ Post first name in contests along with photos on social media outlets

Your Name: _____

Relationship to patient: _____

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;
- 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