Great Expressions
ORTHODONTIC CENTERS

ORTHODONTIC PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Full Name ______________________ (First, Middle, Last) Patient is ☐ Male ☐ Female Patient's Birth Date __________ (Month/Day/Year)

Patient's Address ______________________ (Street, City, State, Zip) Home Phone __________

Patient's Dentist ______________________ (Name, City) Dentist's Phone __________

Whom may we thank for your referral? __________ Other family members seen by us? __________

RESPONSIBLE PARTY INFORMATION

Responsible Party 1 ______________________ (First, Middle, Last) (☐Single ☐ Married ☐Divorced) Relationship to Patient __________

Home Address ______________________ (Street, City, State, Zip) Home Phone __________

Employer and Occupation ______________________ Birth Date __________ (Month/Day/Year) Social Security No. _____/_____/_____

E-mail Address __________ Work Phone __________ Cell Phone __________

Responsible Party 2 ______________________ (First, Middle, Last) (☐Single ☐ Married ☐Divorced) Relationship to Patient __________

Home Address ______________________ (Street, City, State, Zip) Home Phone __________

Employer and Occupation ______________________ Birth Date __________ (Month/Day/Year) Social Security No. _____/_____/_____

E-mail Address __________ Work Phone __________ Cell Phone __________

Primary Insurance & Subscriber __________ Secondary Insurance & Subscriber __________

HEALTH HISTORY

MEDICAL HISTORY - Please check "Yes" or "No" to all items below

- ☐Yes ☐No ADHD/ADD (if so, what medication(s)? __________
- ☐Yes ☐No Asthma (if so, what medication(s)? __________
- ☐Yes ☐No Girls: Started menstruation? First Cycle: __________
- ☐Yes ☐No Boys: Voice changed?
- ☐Yes ☐No Heart Trouble/Murmur (if so, what medication(s)? __________
- ☐Yes ☐No Artificial Joints (If so, when?) __________
- ☐Yes ☐No Joint Swelling or Arthritis
- ☐Yes ☐No Prolonged Bleeding
- ☐Yes ☐No Endocrine Problems
- ☐Yes ☐No Diabetes
- ☐Yes ☐No Bone Disorders
- ☐Yes ☐No Hepatitis or Liver Problem
- ☐Yes ☐No Tuberculosis (TB)
- ☐Yes ☐No AIDS or HIV
- ☐Yes ☐No Epilepsy
- ☐Yes ☐No Tonsils Removed (If so, when?) __________
- ☐Yes ☐No Are you pregnant? How far along? __________
- ☐Yes ☐No Seasonal Allergies Meds: __________
- ☐Yes ☐No Drug Allergies Which Ones? __________
- ☐Yes ☐No Latex Allergies
- ☐Yes ☐No Nickel Allergy
- ☐Yes ☐No Nut Allergy

DENTAL HISTORY - Please check "Yes" or "No" to all items below

Date of last dental cleaning: __________

- ☐Yes ☐No Any injuries to ☐face, ☐mouth, ☐teeth?
- ☐Yes ☐No Thumb, finger or lip sucking habit(s)? Discontinued at age __________
- ☐Yes ☐No Mouth breathing when ☐awake, ☐asleep?
- ☐Yes ☐No Any known missing permanent teeth? __________
- ☐Yes ☐No Any known extra permanent teeth? __________
- ☐Yes ☐No Any teeth removed by extraction? If so, when __________
- ☐Yes ☐No A tongue thrust problem? ☐Speech problems?
- ☐Yes ☐No Any clenching or grinding of teeth? ☐Day ☐Night ☐Both
- ☐Yes ☐No Any pain, popping or locking on opening or closing jaw?
- ☐Yes ☐No Frequent headaches? If so, number per week _____ ☐AM ☐PM
- ☐Yes ☐No Any muscle tenderness or stiffness in the ☐jaw ☐neck?
- ☐Yes ☐No Any ☐ringing sounds in the ear or ☐spells of dizziness?
- ☐Yes ☐No Any previous treatment for TMJ or jaw point problems?
- ☐Yes ☐No Any previous orthodontic evaluation or treatment?
- ☐Yes ☐No Are you under doctor's care now?

For what? __________

Name of Physician: __________

Physician's Phone: __________

PLEASE LIST YOUR **CHIEF CONCERN(S)** AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH:

____

____

Signature of Person Completing Form: ______________________ Date: __________

Updated Health History/ Personal Infomation:

Date:	Date:	Date:	Date:	Date:
Initials:	Initials:	Initials:	Initials:	Initials:

Great Expressions®
DENTAL CENTERS

SECTION A: PATIENT GIVING CONSENT

Patient Name: ____________________

Address: ____________________

Telephone: ____________________ E-mail: ____________________

Patient Number: ____________________ Social Security Number: ____________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: **Elaine Olejnik, R.D.H., B.S.**
Telephone: **248-203-1134 Fax: 248-686-0154**
Address: **29777 Telegraph Road, Suite 3000, Southfield, MI 48034**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, ____________________ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature: ____________________ Date: ____________________

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ____________________

Relationship to Patient: ____________________

SECTION D: 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
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify) ____________________

Signature: ____________________ Date: ____________________

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I, ____ , understand that by signing this Consent form, I am giving my consent to Great Expressions Dental Centers to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: ______________________________

Relationship: ______________________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

______________________________ ______________

Patient's Signature (Legal Guardian, if Patient is a minor) Date:

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Great Expressions Dental Centers restrict the disclosure of my PHI to those specified below:

Name: ______________________________

Name: ______________________________

Signature: ______________________________ Date: ______________

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________