SMILES for LIFE
ORTHODONTICS

Irelia Machado, DDS, MS

Welcome to Smiles for Life Orthodontics!

We are excited that you are considering orthodontics treatment. You and your needs are our primary focus. Our goal is to help you achieve a beautiful smile and a correct, healthy bite. We look forward to providing you and your family with the best and most technically advanced orthodontic treatment available today.

We pride ourselves in using the most current materials and state-of-the-art techniques to be certain that you receive comfortable, healthy-centered and time efficient treatment. With over 10 years' experience, Dr. Machado and team are dedicated to helping you and/or your child achieve a healthy, attractive smile. You will find our staff to be knowledgeable and caring and our office environment warm and friendly. You are special to us; you will be treated like part of our family.

At you initial visit, we will give you a complete evaluation, including records, at no charge. Dr. Machado will discuss with you her treatment recommendations (if any), and together you will determine the ideal method of treatment for you or your child.

Attached you will find all the necessary forms. Please fill all the information and bring them with you the day of the appointment.

Please do not hesitate to call if you have any questions. Looking forward to meeting soon!

Dr. Irelia Machado and Team

PATIENT INFORMATION

Patient's Name *Today's Date*

Address *City* *State* *Zip*

Home Phone

Birthday

SS# or Insurance ID

Patient's Dentist

Last Date of Cleaning

How did you hear about our office?

- ☐ School
- ☐ Facebook
- ☐ Google
- ☐ Friend
- ☐ Dentist
- ☐ Walk-in
- ☐ Flyer
- ☐ Program
- ☐ AMC Ad
- ☐ Local Event
- ☐ Other: _____

Has any member of your family previously undergone orthodontic treatment?

- ☐ Yes
- ☐ No

RESPONSIBLE PARTY INFORMATION

Responsible Party Name *Relationship to Patient*

Mailing Address *City* *State* *Zip*

Years at Current Address *Home Phone* *Mobile Phone* *Work Phone*

Email *Birthday* *DL #* *SS #*

Occupation & No. of Years *Employer* *Employer Address*

PARENT / GUARDIAN INFORMATION

Father / Guardian Name

☐ Check if 'Responsible Party' info is the same

Mailing Address | *City* | *State* | *Zip*

Years at Current Address | *Home Phone* | *Mobile Phone* | *Work Phone*

Email | *Birthday* | *DL #* | *SS #*

Occupation & No. of Years | *Employer* | *Employer Address*

Mother / Guardian Name

☐ Check if 'Responsible Party' info is the same

Mailing Address | *City* | *State* | *Zip*

Years at Current Address | *Home Phone* | *Mobile Phone* | *Work Phone*

Email | *Birthday* | *DL #* | *SS #*

Occupation & No. of Years | *Employer* | *Employer Address*

DENTAL HISTORY

Please check **Yes** or **No** if the patient has, or has ever had the following:

Y	N		Y	N	
◯	◯	Any injury to face, mouth, or teeth?	◯	◯	Clenching or Grinding of teeth?
◯	◯	Thumb, finger, or lip sucking habit(s)?	◯	◯	Chronically sore or bleeding gums?
◯	◯	Any speech problems?	◯	◯	Jaw Pain, popping, grinding, locking?
◯	◯	Mouth breathing when asleep, awake?	◯	◯	Difficulty chewing or swallowing food?
◯	◯	Any known missing permanent teeth?	◯	◯	Frequent Headaches?
◯	◯	Any known extra permanent teeth?			If yes, how frequent?_____
◯	◯	Any teeth removed by extraction?	◯	◯	Muscle tenderness/stiffness in neck/jaw?
		If yes, when:_____	◯	◯	Ringing of ear, dizziness?
◯	◯	Tongue thrust?	◯	◯	Previous treatment for TMJ or joint problems?
◯	◯	Any wind instruments played?			

Please list dates and specifics for all “Yes” answers:

Does patient visit his/her dentist regularly? ☐ Yes ☐ No

Has an Orthodontist been consulted previously? ☐ Yes ☐ No

Reason: _____

Has patient experienced a sudden increase in height? ☐ Yes ☐ No

Does any member of the family or close relative(s) have a similar arrangement of teeth or similar appearance of the jaws? ☐ Yes ☐ No

Explain: _____

Please list any other dental information known, and not listed above:

MEDICAL HISTORY

Please check **Yes** or **No** if the patient has, or has ever had the following:

Y	N		Y	N	
◯	◯	Joint Swelling or Arthritus	◯	◯	Anemia
◯	◯	Bone Disorders	◯	◯	Asthma
◯	◯	Heart Problems	◯	◯	Epilepsy
◯	◯	Diabetes	◯	◯	Prolonged Bleeding
◯	◯	Thyroid Problems	◯	◯	Endocrine Problems
◯	◯	Kidney Problems	◯	◯	Tonsils Removed
◯	◯	Rheumatic Fever	◯	◯	Adenoids Removed
◯	◯	Hepatitis or Liver Problems	◯	◯	Tobacco Usage
◯	◯	Emotional Problems			(cigarettes ☐ smokeless ☐)
◯	◯	Tuberculosis	◯	◯	Has puberty begun?
◯	◯	AIDS / HIV	◯	◯	Has menstration begun? (girls)

Please list dates and specifics for all “Yes” answers:

List any allergies: _____

List medications presently being taken: _____

List any serious illness or operation not listed above: _____

Is the patient currently under a physicians care? ☐ Yes ☐ No

Physician’s Name: _____

Reason: _____

The above information in both the Medical & Dental History sections, is true to the best of my knowledge, and I understand that it is my obligation to update this information as changes become known to me.

Patient / Parent / Guardian Signature *Date*

Doctors comments: _____

SMILES for LIFE
ORTHODONTICS

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 10/01/2012 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. Irelia Machado.

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:

- We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you (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.); These professionals will have a privacy and confidentiality policy like this one.

- To third party payers 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 hear incidental disclosures about your treatment scheduling, etc.);

- To your family and close friends involved in your treatment;

• We may contact you to provide appointment reminders or information about your treatment alternatives or other health-related benefits and services that may be of interest to you. The reminders include texts, voicemail messages, postcards or letters.

• We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

• We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

• 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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

• We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

• We will not use your health information for marketing purposes unless we have your written authorization to do so.

• The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

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. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $25.00 for the first 20 pages, then $0.15 each additional page. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

• Amend or modify your protected health information in certain circumstances; You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended.

• 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 inquires 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 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.

• Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is 'breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

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 ACKNOWLEDGEMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient / Parent / Guardian Signature *Date*

SMILES for LIFE
ORTHODONTICS

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign, and date this form.

Your protected health information (i.e., individually identifiable information such as names, date, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account, or health care operations (i.e., performance reviews, certification, accreditation, and licensure).

You have the right to review our office's privacy notice prior to signing this consent, a copy of which can be given to you with this consent.

You have the right to request restrictions on the use of you protected health information. However, we are not required to, and may not, honor your request.

We may amend the privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient / Parent / Guardian Signature *Date*

SMILES for LIFE
ORTHODONTICS

FOR PATIENTS WITH INSURANCE COVERAGE

We file insurance as a courtesy to our patients. If you would like our office to submit your dental insurance for you, we ask that you read and agree to the following:

The portion of the fee not paid by insurance is the responsibility of the patient. We ask that you pay your estimated portion. We do our best to figure each patient's out of pocket expense.

However, the amount we give each patient is **JUST AN ESTIMATE**, and is based on information we have received from your insurance company. Not all information is available to us, and therefore, the amount we estimate is not a guarantee of further financial responsibility for each patient.

Signature *Date*

I authorize release of any information relation to this claim. I understand that I am responsible for all costs of orthodontic treatment.

Signature *Date*

I hereby authorize payment of the orthodontic benefits otherwise payable to me directly to Smiles for Life Orthodontics.

Signature *Date*

I understand the anticipated orthodontic benefit is a good faith estimate based on verbal or written verification of benefits from my insurance company. The orthodontic benefit is usually not paid lump sum, but rather spread out in monthly, quarterly, semi-annual, or annual payments. While we have done our best to estimate the benefit amount, the amount paid can vary due to waiting periods, deductibles, sliding fee scales, fee schedule payments, or cancellation of the insurance policy. The policyholder is responsible for advising the orthodontic office of any changes in insurance coverage. Any amount unpaid by insurance FOR ANY REASON, becomes the responsibility of the patient/responsible party.

SUBMIT