Questionnaire

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New Patient Information Questionnaire

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Gronberg Orthodontics
New Patient Information Questionnaire

Patient Information

Patient's Last Name:
Patient's First Name:
Patient's Nickname:
Patient Gender:
Male ☐ Female ☐
Patient's Birthdate:
Patient's Age:
Patient's Street Address:
Patient's City:
Patient's State:
Patient's Postal Code (Zip Code):
Cell Phone Number for Appointment Reminders:
Email Address for Appointment Reminders:
*****
Patient's General Dentist:
Last Appointment with Dentist?
If a student- Patient's School:
If a student -Patient's Grade:
Patient's Hobbies/Activities:
If you are filling out for your child- Sibling(s) Name and Birthdate(s) The American association of orthodontics recomends screening at age 7. We can send you reminders when they are due.
Name:{} Birthdate{} Name:{} Birthdate{} Name:{} Birthdate{}
Name:{} Birthdate{} Name:{} Birthdate{}
Which method(s) would you prefer to receive notifications of you future appointments? Check all that apply.
Email ☐ Text Message ☐ None ☐
Whom may we thank for referring you to our office?
What concerns you most about your teeth?

Billing Party Information
(Person financially responsible)

(Person financially responsible for making payments)

Billing Party's Last Name:
Billing Party's First Name:
Billing Party's Nick Name:
Billing Party's Gender:
Male ☐ Female ☐

Billing Party's Birthdate:

Billing Party's Address:

Billing Party's City:

Billing Party's State:

Billing Party's Postal Code (Zip Code):

Billing Party's Cell Number:

Billing Party's Home Number:

Billing Party's Work Number:

Billing Party's Social Security #:

Marital Status:

Single ☐	Married ☐	Widowed ☐
Separated ☐	Divorced ☐	

Billing Party Relationship to Patient:

Self ☐	Mother ☐	Father ☐
Aunt ☐	Uncle ☐	Grandmother ☐
Grandfather	Guardian ☐	Other

Billing Party's Email Address:

Occupation:

Employer:

Number of years employed:

Dental Insurance Information

If you have dental insurance, please provide the following information so we can verify your benefits before your scheduled appointment.

Primary Insurance Policy Coverage:

Policy Holder's Name (Last Name, First Name):

Policy Holder's Address if Different From Patient:

Policy Holder's Date of Birth:

Policy Holder's Social Security #:

Insurance Company Name:

Insurance Company Phone Number:

Policy Holder's ID Number:

Group or Local Number:

Name of Subscriber's Employer:

Policy Holder's Relationship to Patient:

Medical History

Physician's Name (Last Name, First Name):

Physician's Phone Number

Date of Last Visit:

Has the patient ever had any of the following medical concerns? (Check all that apply)

Abnormal Bleeding ☐	Anemia ☐	Artificial Bones / Joints / Valves ☐
Arthritis ☐	Asthma- List any Asthma triggers{} ☐	Blood Transfusion ☐
Bone Disorders ☐	Cancer / Chemotherapy ☐	Congenital Heart Defects ☐
Diabetes ☐	Difficulty Breathing ☐	Drug Abuse ☐

Emotional Problems ☐	Endocrine ☐	Emphysema ☐
Epilepsy / Seizures / Fainting ☐	Fever Blisters / Herpes ☐	Glaucoma ☐
Heart Attack / Stroke ☐	Heart Murmur ☐	Heart Surgery / Pacemaker ☐
Hemophilia ☐	Hepatitis ☐	High / Low Blood Pressure ☐
HIV+ / AIDS ☐	Hospitalized for Any Reason ☐	Kidney Problems ☐
Mitral Valve Prolapse ☐	Psychiatric Problems ☐	Radiation Treatment ☐
Rheumatic / Scarlet Fever ☐	Severe / Frequent Headaches ☐	Shingles ☐
Sickle Cell Diease / Traits ☐	Sinus Problems ☐	Tobacco Usage (Frequency): {} ☐
Tuberculosis ☐	Tonsils/Adenoids Removed? ☐	Ulcers / Colitis ☐
Veneral Disease ☐	Please list any other illness/medical condition(s): {} ☐	Any medical condition that requires pre-medication: {} ☐
Sleep Apnea or Snoring ☐	Autism ☐	Autism Spectrum ☐
No Medical Concerns ☐		

Is the patient allergic to any of the following?
(Check all that apply)

Aspirin ☐	Any Metals / Plastics ☐	Codeine ☐
Dental Anesthetics ☐	Erythromycin ☐	Latex ☐
Penicillin ☐	Tetracycline ☐	Other (Please indicate in the entry below) ☐
No Allergies		

Other Allergies:

Please list any medications now being taken by the patient:

If patient is a child- Has Puberty/Menstruation Began? Age of Onset?

Yes, Date:{} ☐ No ☐

Dental History

Please check ALL Dental Concerns that apply:

Has patient ever sucked thumb or fingers? ☐	Does the patient breathe predominantly through the mouth? ☐	Does the patient have any speech problems? ☐
Has the patient had any head, mouth or facial injuries? ☐	Have any teeth been chipped due to accidents? ☐	Have you been informed of missing permanent teeth? ☐
Have you been informed of any extra teeth? ☐	Were any teeth (baby or permanent) removed by extraction? ☐	Was it suggested that the space be maintained? ☐
Was an appliance placed to maintain the space? ☐	Does the patient clench or grind teeth? ☐	Does the patient have pain or clicking in the jaw? ☐
Any noticeable difficulty in chewing or swallowing food? ☐	Any TMJ Disorders or Previous TMJ Treatment? ☐	Tongue Thrust? ☐
Previous Periodontal Treatment? ☐	Chronically Inflamed or Bleeding Gums? ☐	Does anyone in family have similar dental condition? ☐
Would patient mind wearing "braces"? ☐	Have you ever had any previous orthodontic consultation or treatment? ☐	No dental problems ☐

For Women

Are you pregnant?

Yes ☐ No ☐

Number of Weeks:

Are you nursing?

Yes ☐ No ☐

Emergency Contact Information

Please provide a name of an emergency contact:

Emergency Contact's Name (Last Name, First Name):

Emergency Contact's relationship to patient:

Emergency Contact's Phone Number:

HIPAA - Notice of Privacy- Practices Gronberg Orthodontics 3000 Village Parkway Suite 430 Highland Village TX 75077

This notice decribes how health information about you may be used and disclosed and how you can get access to this information.
Your Information. Your Rights.
Our Responsibilities.
Please read it carefully.

Page 1
YOUR RIGHTS- You have the right to :
* Get a copy of your paper or elecronic medical record
*Correct your paper or electronic medical record
*Request confidential communication
*Ask us to limit the information we share
*Get a list of those with whom we've shared your information
*Get a copy of this privacy notice
*Choose someone to act for you
*File a complaint if you believe your privacy rights have been violated

-See page 2 for more information on how to exercise you rights

YOUR CHOICES- You have some choices in the way that we use and share information as we:
*Tell family and friends about your condition
*Provide disaster relief
*Include you in a hospital directory
*Provide mental health care
*Market our sevices and sell your information
*Raise funds
-See page 3 for more information on these choices and how to exercise them

OUR USES AND DISCLOSURES -We may use and share your information as we:
*Treat you or your child
*Run our organization
*Bill for your services, including insurance billing
*Help with public health and safety issues
*Do research
*Comply with the law
*Respond to organ and tissue donation requests
*Work with a medical examiner or funeral director
*Address workers' compensation, law enforcement, and other government requests
*Respond to lawsuits and legal actions
See page 3 and 4 for more information on these uses and disclosures

*

PAGE 2
YOUR RIGHTS - When it comes to your health information ,you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get and electronic or paper copy of your medical record-
* You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
*We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost- based fee.

Ask us to correct your medical record-
*You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us

how to do this.
*We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications-
*Your can ask us to contact you in a specific way (for example, home or office phone) or send mail to a different address.
*We will say "yes" to all reasonable requests.

Ask us to limit what we use or share-
*You can ask us NOT to use or share certain health information for your treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
*If you pay for a service or health care item out-of -pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes"unless a law requires us to share that information.
Get a list of those we've shared information-
*You can ask for a list (accounting) of the times we've shared you health information for six years prior to the date you ask, who we shared it with, and why.
*We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable,cost-based fee if 2 in 12 months.

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Get a copy of this privacy notice-
* You can ask for a paper copy of this notice at any time, even if you have agreed to recieve this notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you-
*If you have given someone medical power of attorney or if someone is your legal guardian, that person can excercise your rights and make choices about your health information.
* We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated-

*You can complain if you feel we have violated you rights by contacting us using the information on page 1.
*You can file a complaint with the U.S. Deptartment of Heath and Human Sevices Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
*We will not retaliate against you for filing a complaint.

Page 3
Your choices- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do , and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
*Share information with your family, close friends, or others involved in your care
*Share information in a disaster relief situation
*Include your information in a hospital directory
If you are not able to telll us your preference, for example if you are unconcious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us permission:
*Marketing purposes
*Sale of your information
*Most sharing of phychotherapy notes

In the case of fundraising:
*** We may contact you for fundraising efforts, but you can tell us not to conact you again.**

Our uses and disclosures-
How do we typically use or share your health information? We typically use or share your health information in the following ways.-
Treat you or your child-
***We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.**
Run our organization:
*** We can use and share your health information to run our practice, improve you care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.**
Bill for your services
***We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.**
Continued next page

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How else can we use or share your health information? We are allowed or required to share your information in other ways- usually in ways that contribute to the pubilic good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs/gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
*** We can share health information about you for certain situations such as:**
***Preventing disease**
***Helping with product recalls**
***Reporting advese reactions to medications**
***Reporting suspected abuse, neglect, or domestic violence**
***Preventing or reducing a serious threat to anyone's health or safety**

Do reasearch
***We can use or share your information for health research.**
Comply with the Law
***We can share information about you if state or federal law requires it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.**
Respond to organ and tissue donation requests-
***We can share health information about you with organ procurement organizations.**

Work with a medical examiner or funeral director
***We can share health information with a coroner, medical examiner, or funeral director when an individual dies.**
Address worker's compensation, law enforcement, and other government requests-
*** We can use or share health information about you:**
*** For workers' compensation claims**
***For law enforcement purposes or with a law enforcement official**
***With health oversight agencies for activities authorized by law**
***For special government functions such as military, national security, and presidential protective services**
Respond to lawsuits and legal actions
*** We can share health information about you in response to a court or administrative order, or in response to a subpoena,**

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Our Responsibilities-

* We are required by law to maintain the privacy and seurity of your protected health information.
*We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices decribed in this notice and give you a copy of it .
*We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Changes to the terms of this notice- We can change the trerms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice of privacy practices applies to the following organizations.
Gronberg Orthodontics
3000 Village Parkway Ste. 430
Highland Village TX 75077
972-966-2326
Email: info@gronbergorthodontics.com
Privacy Officer : Dr Kimberly Gronberg
Updated 5/1/2017

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. By signing or electronically signing at the end of this form you acknowledge receipt of the Notice provided above. Also available in our office or on our website.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. You may print this form here, from our website or request copy in office.
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
Gronberg Orthodontics

By signing below, I am acknowledging that:
- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Gronberg Orthodontics; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Signature of patient or parent/legal guardian/legally responsible person. If submitting this form electronically, my submission of this form is acknowledged as my electronic signature. If on paper my signature at the end of this form is my acknowledgement of reciept of privacy practices.

Gronberg Orthodontics may communicate with me about my oral health, treatment, appointments, and post-operative follow-ups by mail, e-mail, text or by phone to the contact information on file. It is my responsibility to ensure all my contact information is up-to-date.

I understand that communication between Gronberg Orthodontics and I may not be encrypted and my information could be intercepted by unauthorized persons.

Gronberg Orthodontics will not be responsible for any unauthorized interceptions. However, we will make

reasonable measures to ensure proper delivery or notification of our patient's information. Examples include, but are not limited to, post-operative phone calls and appointment reminders.

This consent remains in effect until expressly revoked (in writing).

Name of person completing this form

Relationship to patient

Date:

By submitting this form electronically, I acknowledge that I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions I may have made in the completion of this form for myself or my child. If there are any changes later to this history record or medical / dental status, I will so inform the practic If submitting this electronically, typing my name in this box and submission of this form is acknowledged as my electronic signature.

SIGNATURE OR ELECTRONIC SIGNATURE(type name if electronic) X

Thank you for completing this form.
If you are in office you may take the i-pad or form to a staff member.
If you are completing online please check for unanswered questions and submit. Thank you!