Questionnaire

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New Patient Questionnaire Gronberg Sugay Ortho

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Gronberg Sugay Orthodontics
New Patient Information Questionnaire

Patient Information

Patient's Last Name:

Patient's First Name:

Patient's Nickname:

Biological sex at birth (required by Texas law):

Male | Female

Patient's Birthdate:

Patient's Age:

Patient's Street Address:

Patient's City:

Patient's State:

TX

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?
If none check the last box for No 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 /Asperger's Syndrome

No Medical Concerns

Is the patient allergic to any of the following?
If none check the last box No Allergies.
(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:
If none check the last box - No dental problems

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:

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 Sugay Orthodontics 3000 Village Parkway Suite 430 Highland Village TX 75077

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Gronberg Sugay Orthodontics

Privacy Officer: Kimberly Gronberg
Effective Date: 01/19/2026

Our Responsibilities
By law, Gronberg Sugay Orthodontics must:

- **Maintain the privacy of your protected health information (PHI).**
- **Provide you this Notice describing our legal duties and privacy practices.**
- **Notify you if a breach occurs that may have compromised the privacy or security of your PHI.**
- **Follow the terms of this Notice currently in effect.**

How We May Use and Disclose Your Information
We may use or disclose your PHI for the following purposes without your written authorization:

- **Treatment: To provide, coordinate, or manage your dental care. Example: sharing radiographs and information with a dental specialist about your treatment.**
- **Payment: To obtain payment for services. Example: sending information to your dental insurance company.**
- **Healthcare Operations: For business activities that support our practice. Example: quality**

Other Permitted Uses & Disclosures
We may also use or disclose PHI without your authorization in these situations:

- **Required by Law: To comply with federal, state, or local laws.**
- **Public Health: For disease control, product recalls, adverse events.**
- **Health Oversight: To government health agencies for oversight activities.**
- **Judicial & Administrative Proceedings: In response to valid subpoenas or court orders.**
- **Law Enforcement: For reporting certain injuries, locating suspects, or complying with law.**
- **Coroners, Medical Examiners, and Funeral Directors: As needed for duties.**
- **Organ and Tissue Donation: If you are an organ donor.**
- **Research: When approved by an institutional review board or privacy board.**
- **Serious Threats: To prevent or lessen a serious threat to health or safety.**
- **Workers' Compensation: To comply with workers' compensation laws.**
- **Fundraising Communications: We do not currently use your information for fundraising purposes. If we ever do, you have the right to opt out of receiving such communications.**
- **Business Associates: We may disclose your information to business associates who perform services on our behalf (e.g., billing services, IT support). They are required to protect your information.**
- **Legal and Regulatory Requirements: We may disclose your information when required by**

Uses & Disclosures Requiring Your Authorization
We must obtain your written authorization before using or disclosing your PHI for:

- **Marketing communications not permitted by law.**
- **Sale of your PHI.**

- **If you give authorization, you may revoke it at any time in writing.**
- **Substance Use Disorder (SUD) Information: If we maintain records related to substance use disorder treatment that are subject to 42 CFR Part 2, those records receive special federal protections. Such information will not be used or disclosed without your specific authorization, except as permitted or**

Your Rights Regarding Your PHI

You have the right to:

- **Get a copy of your health records**
- **Request corrections to your health records**
- **Request confidential communications**
- **Ask us to limit what we use or share**
- **Get a list of disclosures**
- **Get a copy of this Notice**
- **Choose someone to act for you**
- **File a complaint if you believe your privacy rights have been violated**

We will not retaliate against you for filing a complaint.

Your Choices

For certain information, you can tell us your choices about what we share, including:

- **Sharing information with family or friends involved in your care**
- **Leaving messages with appointment information**

If you have a clear preference, we will follow your instructions unless required otherwise by law.

Breach Notification

If a breach occurs that compromises the privacy or security of your PHI, Gronberg Sugay Orthodontics will notify you without unreasonable delay and no later than 60 days after discovery of the breach.

Contact Information

If you have questions, requests, or complaints about this Notice or your privacy rights, contact: Gronberg Sugay Orthodontics, HIPAA Privacy Officer: Dr. Kimberly Gronberg, Address: 3000 Village Pkwy, Suite 430, Highland Village, Texas 75077, Phone: (972) 966-2326

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, Voice Phone (toll-free): 1(800) 368-1019 |TDD (toll-free): 1(800) 537-7697 Email: OCRMail@hhs.gov. You will not be penalized in any way for filing a complaint.

Changes to This Notice

We reserve the right to change our privacy practices and this Notice. Updates will apply to all PHI we maintain. Revised notices will be posted in our office and on our website, if applicable, and available upon request.

Effective Date: 01/19/2026

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 Sugay 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 Sugay 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 Sugay 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 Sugay Orthodontics and I may not be encrypted and my information could be intercepted by unauthorized persons.

Gronberg Sugay 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.

Name of person completing this form:

Relationship to patient:

Date:

By submitting this form electronically or in printed form. I acknowledge that I have read and understand the above questions. I have received a Notice of Privacy Practices. 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 practice. 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 please hand in form to a staff member.
If you are completing online please check for unanswered questions and print or submit. Thank you!