TRI-CITY ORTHODONTICS

INFORMACION DE PACIENTE

Nombre De Paciente: _____ _____ _____ _____
APELLIDO NOMBRE SEGUNDO NOMBRE PREFERIDO

☐ Masculino ☐ Femenimo **F**echa **D**e **N**acimineto: _____ Edad: _____ Mejor numero telefonico:_____

Domicilio: _____ _____ _____ _____
CALLE CIUDAD ESTADO CODIGO POSTAL

Dentista: _____ Fecha de ultima cita? _____

Tiene trabajo dental pendiente? ☐ No ☐ Si… Por favor describa: _____

A quien podemos agradecer por refirirle? _____

INFORMACION DE HERMANO/A(S):

Nombre_____ FDN_____ Nombre_____ FDN_____

Nombre_____ FDN_____ Nombre_____ FDN_____

Padre(s)/Guardian

Nombre: _____ Relacion: _____ SS #:_____ FDN: _____

Domicilio: _____ Telefono de casa #_____ Cell #_____ Trabajo#_____

Empleador: _____ Ocupacion: _____

Nombre: _____ Relacion:_____ SS #_____ FDN:_____

Domicilio: _____ Telefono de casa #_____ Cell #_____ Trabajo #_____

Empleador: _____ Ocupacion: _____

Aseguranza Dental (Por favor facilitar su targeta de asuguranza)

Compania de Aseguranza: _____ **ID#**_____ Grupo #_____

Nombre de Suscriptor: _____FDN: _____ Relacion: _____

Empleador: _____ Ocupacion:_____

Tiene seguro secundario? ☐ No ☐ Si Si, por favor de completar lo siguente:

Compania De Aseguranza: _____ **ID#**_____ Grupo #_____

Nombre de Suscriptor: _____ FDN: _____ Relacion: _____

Empleador: _____ Ocupacion: _____

Informacion de contacto recordatorio

Como el gustaria que le recuerdemos de sus citas en el futuro? Por telefono ☐ Texto ☐ Correo Electronico ☐

Cell # 1) _____ Nombre: _____ Compania de cell:_____

Cell # 2) _____ Nombre: _____ Compania de cell: _____

Correo Electronico 1) _____ 2) _____

AUTORIZACION DE INFORMACION: Yo authorizo la revelacion de cualquier informacion requerida por mi aseguranza con respect a mi tratamiento.
NOTAE: Esta officina no repartira informacion sobre su cuido o repartira copias de sus archivos a nadie sin su permiso con firma.

Firma de Padre(s)/Guardian: _____ Fecha: _____

Por favor complete el siguiente cuestionario de salud tan plena y completamente como sea possible. Tambien escriba cualquier informacion que usted piense que pueda se util.

Paciente……

Que son las preocupaciones del paciente/o padre(s) sobre los dientes y quijada?
……. Amontonamiento
……. Sobre mordida
……. Dientes de conejo
……. Desalinamiento
……. Quijada retrocedido
……. Quijada prominente
……. Espaciamiento
……. Enfermedades de las encias
……. Diented que faltan
……. Disfuncion de la quijada
……. Boca pequena
……. Tronidos de la conyuntura de la quijada
……. Diented de forma irregular
……. Protrusion de dientes
……. Zumbido en los oidos
……. Dolores de cabeza o cara
……. Dolor de cuello
……. Dolor de la quijada
……. Proporciones irregular de la cara
……. Mordida cruzada
……. Bajo mordida
……. Mordida abierta
……. Recomendacion de dentista
……. Segunda opinion
Otro……

Describa la salud fisica del paciente?
……. Excelente ……. Bueno
……. Justo ……. Pobre

Describa la salud mental del paciente?
……. Excelente ……. Bueno
……. Justo ……. Pobre

Enumere por favor cualquier medicacion que este o se ha adquirido una base regular:
……. Pastillas del Corazon……
……. Antibioticos……
……. Pain pills……
……. Pastillas de dolor……
……. Relajantes mosculares……
……. Anti Depresivos/Anciedad……
……
…… Bisfosfonatos……
…… Otros……
……

Con que frequencia el/ la paciente tiene chequeos dentales?
……. Annual
……. Dos veces al ano
……. Mas de dos veces al ano
……. Solo si es urgente (emergencia nomas)
……. Nunca

El paciente a tenido o tiene ahora unas de las sigientes condiciones?
……. Alergias:
……. Temporal
……. Penicilina
……. Latex
……. Metal/Niquel
……. Otro……
……. Anemia
……. Desordenes de la sangre
……. Sangrando prolongado
……. Hepatitis
……. SIDA/VIH positivo
…….Fiebre reumatica
……. Cancer o tumor
……. Deordenes del corazon/ sople cardiaco
……. Tuberculosis
……. Diabetes
……. Desordenes de la endocrina
……. Desordenes de los huesos
……. Epilepsia/ Convulsiones
……. Tonsillitis
……. Mononucleosis
……. Remocion de las anginas
……. Remocion de los adenoides
……. Asma
……. Autoimune
……. Alta presion
……. Alteraciones de sueno
……. Desordenes de comer/ Bulemia
……. Respiracion por la boca
……. Ronquido fuerte
……. Antibioticos pre-medicamietos
……. Dolor de cabeza/cara severo
……. Habito de chuparse el o los dedo
……. Anterior …… Corriente
……. Mordida de unas
……. Juega con instrumentos de viento
……. Tratamientos anterior de TMJ
……. Tratamientos anterior de Orthodoncia
……. Historia familiar de cirujia othrogatic
……. Paladar hendido reparado
……. Osteoporosis
……. Estress emocional

El/ La paciente a alcanzado la puberta?
……. No
……. Si (Fecha approx ……)

El/ La paciente tiene dificultad al masticar?
……. No
……. Si
……. Dientes no responden bien
……. Dolor al masticar
……. Otro……

El/ La paciente tiene dolor/ tronidos en la cojontura de la quijada?
……. No
……. SI
….. Derecha
….. Izquierda

El/ La paciente aprieta o muele los dientes?
……. No
……. Si
……. Indeciso

El/ La paciente ha sido informado que tiene empuje lingual para comer/ beber?
……. No
……. Si
……. Indeciso

Anteriormente a tenido el/ la paciente consultas o examenes de orthodoncia?
……. No
……. Si (Cuando: ……)

Cual es el interes de el paciente/ padre(s) sobre el tratamiento de orthodoncia?
……. Gustaria tratamiento
……. Tratamiento, solamente si es necesario
……. En contra de tratamiento, pero dispuesto a coperar si es necesario
…….Incooperativo

Hay alguna informacion medical, dental o quirurjico que no hemos mencionado que debemos saber acerca de?
……. No
……. Si ……
……

Firme su nombre
Firma de la persona que llena el formulario

Nombre (Escriba)

Fecha

INFORMACION ADICIONAL:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name_____ **DOB**_____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can be used to, but are not excluded to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____ **Date**_____

Printed Name _____

Relationship to Patient: ☐ **Self** ☐ **Parent/Guardian** ☐ **Power of Attorney**

☐ I give my permission for you to discuss medical and/or financial information with:

Name:_____ Relationship to Patient_____
Name:_____ Relationship to Patient_____
Name:_____ Relationship to Patient_____
Name:_____ Relationship to Patient_____

……..

For Office Use Only:

We were unable to obtain the patient's written acknowledgement for our Notice of Privacy Practices Acknowledgement due to the following reasons:

- o Patient/Guardian refused to sign.
- o Communication barriers.
- o Emergency situation.
- o Other

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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 and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775