Naperville@FigOrtho.com
Winnetka@FigOrtho.com

Date _____
MM / DD / YYYY

Patient Information

Patient Full Name: _____
First Middle Last

Preferred Name:_____ Gender:_____ Date of Birth: _____
MM / DD / YYYY

Student Status: Full Time Part Time Non Student If Student, School Attending: _____
Please Circle One

Responsible Party Information

Is patient the responsible party? **Yes** **No** If Yes, skip to "Home Address" -- If No, please complete below:

Title: _____ Full Name: _____ Sex: **M** **F**
First Middle Last

Home Address: _____ City:_____ State:_____ Zip:_____

Phone 1: _____ Cell / Home Phone2: _____ Cell / Home
We will use this number to confirm appointments via Text Please Circle One Please Circle One

Work Phone: _____ Email: _____

Relationship to Patient: _____ Marital Status: Single Married Divorced
Please Circle One

Spouse Title: _____ Spouse Name: _____
First Middle Last

Dental Insurance Information

Is the primary policy holder the responsible party? **Yes** **No** If yes, skip to "policy holder ID #" -- If no, complete below:

Primary Policy Holder Full Name: _____ Sex: **M** **F**
First Middle Last

Home Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Email: _____

Policy ID or SS#:_____Date of Birth: _____ Employer:_____
MM / DD / YYYY

Group #: _____ Insurance Company:_____

Secondary Policy Holder Full Name: _____ Sex: **M** **F**
First Middle Last

Home Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Email: _____

Policy ID or SS#:_____Date of Birth: _____ Employer:_____
MM / DD / YYYY

Group #: _____ Insurance Company:_____

Dentist Information

Dentist: _____ Office Phone: _____

Address :_____ City:_____ State:_____ Zip:_____

How did you hear of our office?_____

Naperville@FigOrtho.com
Winnetka@FigOrtho.com

Dental History

Why are you seeking orthodontic treatment? _____

Does the patient have or have they had any of the following?

[ ] Dental Pain
[ ] Difficulty in Chewing
[ ] Difficulty Opening/Closing Mouth
[ ] Jaw Joint Noise or Pain (TMJD)
[ ] Grinding or Clenching of Teeth
[ ] Injury to Face, Mouth or Jaw
[ ] Bleeding Gums
[ ] Sensitive Teeth
[ ] Sores in Mouth or Lips
[ ] Periodontal Disease
[ ] Missing/Extra Teeth
[ ] Cavities
[ ] Dental Treatment (Crown, Bridge, Implant, etc.)
[ ] Thumb, Finger or Lip Sucking
[ ] Mouth Breathing
[ ] Problems with Tonsils, Adenoids, or Sinuses
[ ] Dissatisfaction with Appearance of Teeth
[ ] Previous Orthodontic Treatment/Consultation

Any other problems or concerns, please explain:_____

_____

Medical History

Physician: _____ Office Phone: _____

Address :_____ City:_____ State:_____ Zip:_____

Is the patient being treated for any medical condition? **Yes** **No** If yes, please explain below:

_____

_____

Does the patient take any medications or supplements? **Yes** **No** If yes, please list with reason for use:

_____

_____

Does the patient have any latex, food, or drug allergies? **Yes** **No** If yes, please list allergies below:

_____

_____

Does the patient smoke or use tobacco of any kind? **Yes** **No** If female, is the patient pregnant or nursing? **Yes** **No**

Patient's Height: _____ Weight: _____ Date of last physical examination:_____
MM / DD / YYYY

Has the patient ever had an illness or injury that required hospitalization? **Yes** **No** If yes, please explain:

_____

_____

Does the patient have or have they had any of the following?

[ ] Heart Disease or Condition
[ ] Artificial Heart Valve
[ ] Rheumatic Fever
[ ] High or Low Blood Pressure
[ ] Bleeding or Blood Problems
[ ] Hepatitis A, B, or C
[ ] AIDS/HIV+
[ ] Diabetes
[ ] Liver Disease
[ ] Kidney Disease
[ ] Herpes
[ ] Venereal Disease
[ ] Drug/Alcohol Addiction
[ ] Tuberculosis (or +PPD)
[ ] Asthma or Breathing Problem
[ ] Seasonal Allergies
[ ] Cancer
[ ] Chemotherapy or Radiation
[ ] Thyroid Disease
[ ] Cleft Lip / Palate
[ ] Bisphosphonate treatment (Boniva, Fosamax, etc.)
[ ] Epilepsy or Seizures
[ ] Arthritis or Joint Problems
[ ] Artificial Joints (Hip/Knee/Other)
[ ] Mental Handicap / Learning Problem
[ ] ADHD
[ ] Depression / Psychiatric Diagnosis
[ ] Autism
[ ] Speech Problems
[ ] Other (Explain Below)

Please indicate any other medical conditions:_____

_____

Signature of Patient/Parent/Guardian: _____ Date:_____

I certify that I have read the above questions and understand tem. I will not hold my orthodontist or any member of their staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my or my dependents medical/dental history.

Alexander Figueroa DMD
Alvaro Figueroa MS DDS

www.FigOrtho.com

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.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law.

This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

How We Will Use or Disclose Your Health Information

Treatment: We will use your health information for treatment. For example, information obtained by the orthodontist or other members of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your orthodontist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations, so the physician will know how you are responding to treatment. We will also provide your physician, or a subsequent healthcare provider, with copies of various reports that should assist him or her in treating you.

Payment: We will use your health information for payment. For example, a bill may be sent to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Health Care Operations: We will use your health information for our regular health care operations. For example, we may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in a continued effort to improve the quality and effectiveness of the services we provide.

Business Associates: We may enter into contracts with persons or entities known as business associates that provide services to or perform functions on our behalf. Examples include our accountants, consultants, and attorneys. We may disclose your health information to our business associates so they can perform the job we have asked them to do, once they have agreed in writing to safeguard your information.

Notification: We may use or disclose information to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided to us, e.g., on an answering machine.

Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Appointment Reminders / Health Benefits: We may contact you to provide appointment reminders or information about treatment alternatives or other health benefits that may be of interest to you.

Funeral Directors and Coroners: We may disclose your health information to funeral directors, and to coroners or medical examiners, to carry out their duties consistent with applicable law.

Organ Procurement Organizations: Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Research: We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also disclose your health information to people preparing to conduct a research project, so long as the health information is not removed from us. We may also use and disclose your health information to contact you about the possibility of enrolling in a research study.

Fundraising: We may contact you as part of our fundraising efforts; however, you may opt-out of receiving such communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health Activities: As required by law, we may disclose your health information to public health, or legal authorities, charged with preventing or controlling disease, injury, or disability.

Health Oversight Activities: We may disclose your health information to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, health information necessary for your health and the health and safety of other individuals.

Judicial and Administrative Proceedings: We may disclose your health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

Law Enforcement Purposes / Serious Threat to Health or Safety: We may disclose your health information to enforcement officials for law enforcement purposes under certain circumstances and subject to certain conditions. We may also disclose your health information to prevent or lessen a serious and imminent threat to a person or the public (when the disclosure is made to someone we believe can prevent or lessen the threat) or to identify or apprehend an escapee or violent criminal.

Victims of Abuse, Neglect, and Domestic Violence: In certain circumstances, we may disclose your health information to appropriate government authorities if there are allegations of abuse, neglect, or domestic violence.

Essential Government Functions: We may disclose your health information for certain essential government functions (e.g., military activity and for national security purposes).

The following uses and disclosures will be made only with your authorization: (i) with limited exceptions, uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in this notice. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

Your Health Information Rights

Although your health record is the physical property of this office, you have the following rights with respect to your health information:

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, our general healthcare operations, and/or to a particular family member, other relatives or close personal friend. We ask that such requests be made in writing on a form provided by us. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it, except as provided below.

- If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We ask that such requests be made in writing on a form provided by us. We are required to abide by such a request, except where we are required by law to make a disclosure. We are not required to inform other providers of such a request, so you should notify any other providers regarding such a request.

- You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing, and submitted to the Privacy Officer. We will attempt to accommodate all reasonable requests.

- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If we maintain your health information electronically in a designated record set, you may obtain an electronic copy of the information. If you request a copy (paper or electronic), we will charge you a reasonable, cost-based fee.

- If you believe that any health information in your record is incorrect, or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by us to make such requests. For a request form, please contact the Privacy Officer.

- You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed six years), as required by law. We ask that such requests be made in writing on a form provided by us. Please note that accounting does not include all disclosures, e.g., disclosures to carry out treatment, payment, or healthcare operations and disclosures made to you or your legal representative or pursuant to an authorization. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.

- You have the right to be notified following a breach of your unsecured protected health information.

- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

For More Information or to Report a Problem

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with us, contact our Privacy Officer by phone or mail as follows:

Jessica Figueroa
847-501-4740
jessica@figortho.com

To file a complaint with the Secretary of HHS, send your complaint to:

U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

If you have any questions or want more information about this Notice of Privacy Practices, please contact our Privacy Officer.

Acknowledged By: _____ Date: _____
Signature of Patient or Personal Representative

PHOTOGRAPHY & MEDIA CONSENT

I hereby give my consent and understand all photographs or videos taken of me or my minor child by Figueroa Orthodontics become the property of Figueroa Orthodontics LLC and may be used by Figueroa Orthodontics LLC for, but not limited to, marketing, professional presentations, website and social media formats.
(Please check one of the options below).

_____ Yes, I give my consent.

_____ No, I do not give my consent.

_____ _____
Patient name Patient/Guardian signature

_____ _____
If patient is a minor, guardian name & relationship to patient Date