RIVERAORTHODONTICS

Rivera Orthodontics
7482 Paseo Del Norte
El Paso, TX, 79911
915-585-7500
www.riveraorthodontics.com

# New Patient Form

| Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you. | Date: / / | Patient #: |
|---|---|---|

## Patient Information

| Title: | First Name: | Middle Name: | Last Name: | I prefer to be called: |
|---|---|---|---|---|
| | | | | |

| Sex: | Age: | Date of Birth (mm/dd/yyyy): / / | Marital Status: | Social Security #: - - | Driver's Licence State & #: |
|---|---|---|---|---|---|
| | | | | | |

| Home Phone: - - | Work Phone: - - | Cell Phone: - - | E-mail Address: |
|---|---|---|---|
| | | | |

| Home Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

| Employment: | Employer's Name: | Employer's Phone: - - | Occupation: |
|---|---|---|---|
| | | | |

| Employer's Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

| Student Status: | School Name (if a full-time student): | Grade: |
|---|---|---|
| | | |

| Best places and times to contact you: | Send appointment reminders via: ❑ Text Message ❑ Email ❑ Mail |
|---|---|
| | |

Please tell us where you heard about us (check all that apply):

❑ Friend or Relative (name): ❑ Newspaper Ad ❑ Radio Ad ❑ TV Ad
❑ Ad in Mail ❑ Saw our Office ❑ Insurance Company ❑ Our Website
❑ Search Engine (Google, etc.) ❑ Other Website:
❑ Other:

Was our website a factor in your decision to visit our practice? ❍ Yes ❍ No

| Name of Spouse (or Parent, if a minor): | Spouse/Parent's Employer: | Spouse/Parent Work Phone: - - | Spouse/Parent Cell Phone: - - |
|---|---|---|---|
| | | | |

| Other family members treated by us: | Additional Comments: |
|---|---|
| | |

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## Emergency Contact

*This should be the nearest relative who does not live with the patient.*

| Title: | First Name: | Last Name: | Relationship to Patient: |
|---|---|---|---|
| | | | |

| Home Phone: | Work Phone: | Cell Phone: | E-mail Address: |
|---|---|---|---|
| - - | - - | - - | |

| Emergency_Contact Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

## Person Responsible for Account

| Title: | First Name: | Middle Name: | Last Name: | Relationship to Patient: |
|---|---|---|---|---|
| | | | | |

| Date of Birth (mm/dd/yyyy): | Social Security #: | Driver's Licence State & #: | Holder of Dental Insurance for Patient: |
|---|---|---|---|
| / / | - - | | |

| Home Phone: | Work Phone: | Cell Phone: | E-mail Address: |
|---|---|---|---|
| - - | - - | - - | |

| Billing Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

| Employment: | Employer's Name: | Employer's Phone: | Occupation: |
|---|---|---|---|
| | | - - | |

| Employer's Address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

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# Insurance Information

## Primary Insurance

| Insurance Holder's Name: | Date of Birth (mm/dd/yyyy): / / | Relationship to Patient: | Employer: |
|---|---|---|---|
| Member ID: | Group ID: | Insurance Company Name: | Insurance Company Phone: - - |

| Insured's SSN: | Insurance Company's Address: | City: | State: | ZIP Code: |
|---|---|---|---|---|

## Secondary Insurance

| Insurance Holder's Name: | Date of Birth (mm/dd/yyyy): / / | Relationship to Patient: | Employer: |
|---|---|---|---|
| Member ID: | Group ID: | Insurance Company Name: | Insurance Company Phone: - - |

| Insured's SSN: | Insurance Company's Address: | City: | State: | ZIP Code: |
|---|---|---|---|---|

## Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Rivera Orthodontics to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Rivera Orthodontics. I permit a copy of this authorization to be used in place of the original. I give Rivera Orthodontics, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

| Signature (Type your name to sign electronically, or print and sign): | Date (mm/dd/yyyy): / / |
|---|---|

# Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

| Signature (Type your name to sign electronically, or print and sign): | Date (mm/dd/yyyy): / / |
|---|---|

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## Payment Policies

*Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.*

### For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

# Dental History

## Previous Dentist

| Dentist Name: | Dental Practice Name: |
|---|---|
| | |

## Last Dental Visit

Last Dental Visit (m/y):
/

## Dental Concerns

*Check all that apply.*

### Teeth

| | | | |
|---|---|---|---|
| ❑ Broken or chipped | ❑ Difficulty chewing | ❑ Tooth pain | ❑ Missing teeth |
| ❑ Crooked | ❑ Loose teeth | ❑ Grinding or clenching | ❑ Orthodontic treatment |

### Facial/Jaw Pain

| | | | |
|---|---|---|---|
| ❑ Frequent headaches | ❑ Pain in temples | ❑ Jaw injury | ❑ Pain around ear |
| ❑ Avoid certain foods | ❑ Jaw locks open/closed | ❑ Head injury | |
| ❑ Popping/clicking | ❑ Pain in jaw | ❑ Neck injury | |

### Other Concerns

| | | |
|---|---|---|
| ❑ Popping/clicking | ❑ Implants - Tooth #: | ❑ Retainer |
| ❑ TMJ | ❑ Jaw locks open/closed | ❑ Dental phobias |
| ❑ Sleep apnea | ❑ Chew on one side | |
| ❑ Orthodontic treatment | ❑ Snoring | |
| ❑ Tooth replacement | ❑ Teeth straightening | |

Does food tend to get caught between your teeth? If yes, where?
Yes

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## Have you ever had:

*Check all that apply.*

❏ Orthodontic treatment ❏ Periodontal treatment ❏ A bite plate or mouth guard
❏ Oral surgery ❏ Your bite adjusted
❏ Any canker sores or cold sores on your lips, tongue, gums, or body
❏ A serious injury to the mouth or head? If yes, please describe including cause:

## Ratings

| | |
|---|---|
| 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ | On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is. |
| 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ | On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned. |
| 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ | On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your level of sensitivity to dental procedures? |
| 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ | On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile. |
| 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ | On a scale of 1-5 (1 poor, 5 great), how do you rate your quality of sleep? |
| 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ | On a scale of 1-5 (1 being low, 5 being high), if you snore, how would you rate the severity of your snoring? |

## Miscellaneous

Has fear ever been an issue for you in a dental office? ❍ Yes ❍ No

Is there anything you don't like about your teeth/smile?

Is there anything you'd like to change about your teeth/smile?

Do you have any upcoming event or circumstances (such as weddings, major surgeries, etc.) we should/need to know about? If yes, what and when?

Yes

Is there anything else you feel we should know?

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# Medical History

How is your general health? ❍Good ❍Fair ❍Poor

Are you currently under medical treatment? If yes, what for?
Yes

Do you require antibiotic pre-medication for your dental work? If yes, what for?
Yes

| Physician's Name: | Phone: - - | Last Visit: / |
|---|---|---|

| Address: | City: | State: | ZIP Code: |
|---|---|---|---|

Do we have permission to contact your doctor regarding your care? ❍Yes ❍No

## Have you ever had:

*Check all that apply.*

- ❑ Arthritis
- ❑ Cancer
- ❑ Emotional problems
- ❑ Head or face injury
- ❑ Heart murmur/trouble
- ❑ Kidney problems
- ❑ Allergies
- ❑ Asthma
- ❑ Blood disease
- ❑ Diabetes
- ❑ Hepatitis A, B, or C
- ❑ Hypertension (high blood pressure)
- ❑ Liver problems
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Anemia
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Seizures
- ❑ Fainting
- ❑ High or low blood sugar
- ❑ Hypotension (low blood pressure)
- ❑ Nervous disorder
- ❑ Artificial valves
- ❑ Congenital heart defect
- ❑ HIV/AIDS
- ❑ Fever blisters
- ❑ Sinus problems
- ❑ Severe/frequent headaches
- ❑ Cancer/chemotherapy
- ❑ Radiation treatments
- ❑ Psychiatric problems
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Hemophilia
- ❑ Abnormal bleeding
- ❑ Cold sores
- ❑ Herpes
- ❑ Hay fever
- ❑ Heart disease
- ❑ Irregular heartbeat
- ❑ Osteoporosis
- ❑ Pain in jaw joints
- ❑ Sexually transmitted disease
- ❑ Sinus trouble
- ❑ TMD/TMJ (jaw pain)
- ❑ Cough-persistent or bloody
- ❑ Latex sensitivity
- ❑ Smoker
- ❑ Tonsillitis
- ❑ Tumor or growth on head/neck
- ❑ Anaphylaxis
- ❑ Genital herpes

## Have you ever had an adverse reaction or allergies to any medication or substance?

*Check all that apply.*

- ❑ Acrylic
- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Dental anesthetics
- ❑ Erythromycin
- ❑ Iodine
- ❑ Latex rubber
- ❑ Metals
- ❑ Nitrous oxide
- ❑ Novocaine
- ❑ Penicillin/antibiotics
- ❑ Sedatives
- ❑ Sulfa drugs
- ❑ Tetracycline
- ❑ Valium
- ❑ Xylocaine

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:
Yes

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ❍Yes ❍No

Do you smoke or chew tobacco? ❍Yes ❍No

Do you use alcohol, cocaine, or other drugs? ❍Yes ❍No

Have you ever had any excessive bleeding requiring special treatment? ❍Yes ❍No

Have you been treated in a hospital in the last five years? ❍Yes ❍No

If female, please mark if you are:
❑ Pregnant - If so, please enter your due date or week #:

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

| Signature (Type your name to sign electronically, or print and sign): | Date (mm/dd/yyyy): / / |
|---|---|

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# HIPAA 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. Please review the following carefully.

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. The Act gives you, the patient, significant new rights to understand and control how your 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 for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim 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.
- To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders

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of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health 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. If you wish to be omitted from any mailings please provide a written notice. 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 provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of March 7, 2017, and 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S.

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Department of Health and Human Services, Office for 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 and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

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## HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Rivera Orthodontics to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

Additionally, I authorize you to share all my protected health information with the following individual(s):

| Name: | Relationship: | Phone: - - |
|---|---|---|
| Name: | Relationship: | Phone: - - |
| Name: | Relationship: | Phone: - - |

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

| Signature (Type your name to sign electronically, or print and sign): | Date (mm/dd/yyyy): / / |
|---|---|

If signing on behalf of someone, explain your relationship to the patient:

## For Office Use Only

*Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.*

The following circumstances prohibited the patient from signing the consent form:

Describe your good faith effort to obtain the individual's signature on this form:

| Office Personnel Signature: | Office Personnel Name: | Office Personnel Title: | Date: / / |
|---|---|---|---|