**Christine K. Abenoja, D.M.D., M.S. CHILD REGISTRATION**

Diplomate, American Board of Orthodontics

**ABENOJA ORTHODONTICS**

**DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHILD’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NICKNAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE\_\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_**

**SCHOOL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GRADE\_\_\_\_\_\_RESIDENT ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PURPOSE OF THIS APPOINTMENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHOM MAY WE THANK FOR REFERRING YOU CHILD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FATHER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MOTHER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FATHER EMPLOYED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW LONG\_\_\_\_\_\_ CELL PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER \_\_\_\_\_\_\_\_**

**MOTHER EMPLOYED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW LONG\_\_\_\_\_\_ CELL PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_CARRIER \_\_\_\_\_\_\_\_\_**

**CHILD’S PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT’S SOCIAL SECURITY NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DRIVER’S LISCENSE NO.\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_**

**DENTAL INSURANCE COVERAGE, NAME OF CARRIER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHILD’S INTEREST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OTHER CHILDREN IN FAMILY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR APPOINTMENT REMINDER, E-MAIL ADDRESS/PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DENTAL HISTORY**

**DATE OF LAST VISIT TO DENTIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DENTIST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR WHAT SERVICE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOES YOUR CHILD BRUSH TEETH DAILY\_\_\_\_\_\_\_\_YES\_\_\_\_\_NO\_\_\_\_\_**

**HAS YOUR CHILD COMPLAINED ABOUT DENTAL DOES YOUR CHILD FLOSS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YES\_\_\_\_\_NO\_\_\_\_\_**

**PROBLEMS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YES\_\_\_NO\_\_\_\_**

**ANY UNHAPPY DENTAL EXPERIENCES\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES\_\_\_NO\_\_\_\_ HOW OFTEN WITH FLOSS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANY INJURIES TO TEETH OR MOUTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YES\_\_\_NO\_\_\_\_\_ ARE DISCLOSING TABLETS USED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YES\_\_\_\_\_NO\_\_\_\_\_**

**ANY MOUTH HABITS- THUMBSUCKING, NAIL BITING, NURSING IS FLUORIDE TAKEN IN ANY FORM\_\_\_\_\_\_\_\_\_\_\_\_\_\_YES\_\_\_\_\_NO\_\_\_\_**

**BOTTLE HABITS, PACIFIER, ETC.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CHILD’S ATTITUDE TOWARD DENTISTRY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANY UNUSUAL SPEECH HABITS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YES\_\_\_NO\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANY LOST OR MISSING PERMANENT TEETH\_\_\_\_\_\_\_\_\_YES\_\_\_NO\_\_\_\_ PREVIOUS ORTHODONTIC TREATMENT?**

**\_\_\_\_\_\_\_\_YES\_\_\_\_\_NO\_\_\_\_\_ If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SUMMARY ( FOR ORTHODONTIST USE ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**HEALTH HISTORY**

**Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last physical examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**YES NO YES NO**

**Are you under care of a physician now\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ] Do you have good physical coordination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]**

**Are you receiving any medication or drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ] Are there any emotional problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]**

**Is there any excessive bleeding when cut\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been hospitalized\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there any allergy to penicillin or other drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are there other allergies: food- pollen-animals-dust-other\_\_\_\_\_\_\_ [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SCREENING QUESTIONS FOR TMJ:**

**YES NO**

1. **Dou you have difficulty or pain, or both, when opening your mouth, as for instance, when yawning? [ ] [ ]**
2. **Does your jaw get “stuck”, “locked”, or “go out”? [ ] [ ]**
3. **Do you have difficulty or pain, or both when chewing, talking, or using your jaw? [ ] [ ]**
4. **Are you aware of noises in the jaw joints? [ ] [ ]**
5. **Do you have pain in or about the ears, temples or cheeks? [ ] [ ]**
6. **Does your bite feel uncomfortable or unusual? [ ] [ ]**
7. **Do you have frequent headaches? [ ] [ ]**
8. **Have you had a recent injury to your head, neck or jaw? [ ] [ ]**
9. **Have you previously been treated for a jaw joint problem? If so, when? [ ] [ ]**

**HAVE YOU HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:**

**\_\_\_\_Anemia**

**\_\_\_\_Asthma**

**\_\_\_\_Bladder**

**\_\_\_\_Cerebral Palsy**

**\_\_\_\_Chicken Pox**

**\_\_\_\_Chronic Sinus**

**\_\_\_\_Convulsions**

**\_\_\_\_Diabetes**

**\_\_\_\_Epilepsy**

**\_\_\_\_Fainting**

**\_\_\_\_Hearing**

**\_\_\_\_Heart**

**\_\_\_\_Hepatitis**

**\_\_\_\_Kidney**

**\_\_\_\_Liver**

**\_\_\_\_Malignancies**

**\_\_\_\_Mastoid**

**\_\_\_\_Measles**

**\_\_\_\_Mononucleosis**

**\_\_\_\_Mumps**

**\_\_\_\_Rheumatic Fever**

**\_\_\_\_Thyroid**

**\_\_\_\_Tuberculosis**

**\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_Venereal Disease**

**Please describe any current medical treatment including drugs, pending surgery, recent injuries, or any other information I should be aware of that we have not discussed.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorizes the Ortho Practice to release any medical or other information about the patient which may be necessary for the proper filing of all insurance claims, review of service or receipt of benefits. In accordance to the HIPPA rules, I give permission for this patient’s treatment to be discussed with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**ASSIGNMENT OF BENEFITS: The undersigned assigns to and authorizes direct payment of benefits to the Ortho Practice. The undersigned also agrees to assist in processing all claims for benefits.**

**FINANCIAL RESPONSIBILITY: The Dental practice strives to provide the best possible medical care for its patients. We expect that we will be paid for the services rendered. The undersigned agrees to be totally responsible for all charges for services rendered to the patient, including any non-covered charges. The undersigned also agrees that if the unpaid account is referred to an attorney for collection, to pay all costs of collections, including reasonable attorney fees of one third of the balance due.**

**In accordance to the HIPPA rules I give permission for this patient’s treatment to be discussed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**and for the correspondence concerning this patient to be communicated to his/her general dentist and her physician.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/ Responsible Party (Agreement to Pay) Guarantor (Agreement to Pay)**

**Abenoja Orthodontics**

**Christine K. Abenoja, D.M.D., M.S.**

Diplomate, American Board of Orthodontics

**NOTICE OF PRIVACY PRACTICES**

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

**PLEASE REVIEW IT CAREFULLY,**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**

**We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10-15-2003 and will remain in effect until we replace it.**

**We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.**

**You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact using the information at the end of the Notice.**

**USES AND DISCLOSURES OF HEALTH INFORMATION**

**We use and disclose health information about you for treatment, payment, and healthcare operations. For example:**

**Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.**

**Payment: We may use and disclose your health information to obtain payment for services we provide for you.**

**Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities.**

**Your Authorization: I addition to our use of your healthcare information for treatment, payment, or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.**

**To Your Family and Friends: We must disclose your health information to you, as described in the Patient Right section of this Notice. We may disclose your health information to a family member, friend or any other person the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.**

**Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such use of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly 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.**

**Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.**

**Required by Law: We may use or disclose your health information when we are required to do so by law.**

**Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.**

**Abenoja Orthodontics**

**Christine K. Abenoja, D.M.D., M.S.**

Diplomate, American Board of Orthodontics

**ACKNOWLEDGEMENT OF RECIEPT OF**

**NOTICE OF PRIVACY PRACTICES**

**“You may refuse to sign this acknowledgment.”**

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received a copy of this office’s Notice of Privacy Practices.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Print Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**For Office Use Only**

**We attempted to obtain written acknowledgment of our Notice of Privacy Practices,**

**but acknowledgement could not be obtained because:**

**\_\_\_\_Individual refused to sign**

**\_\_\_\_Communication barriers prohibited obtaining the acknowledgment**

**\_\_\_\_An emergency situation prevented us from obtaining acknowledgement**

**\_\_\_\_Other (please specify)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Abenoja Orthodontics**

**Christine K. Abenoja, D.M.D., M.S.**

Diplomate, American Board of Orthodontics

**Insurance Information**

**If you have an insurance plan that covers orthodontic treatment and you would like to use that coverage for part of your orthodontic fee, we will be happy to assist you in claiming your benefits. With increasing number of dental insurance programs, we find it impossible to have complete and accurate knowledge about all of these programs and our individual patient’s status with respect to his program.**

**Therefore, to facilitate processing your claim, we have adopted the following standardized procedure.**

**In order to process your insurance claim properly we need the following information. This may be obtained by contacting your insurance company of the personnel department where you are employed.**

**Lifetime Maximum: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payable at: \_\_\_\_\_\_\_\_% Effective Date: \_\_\_\_\_\_\_\_\_\_\_**

**Age Limit for Orthodontic Benefits: \_\_\_\_\_\_\_**

**Circle One:**

**Pays orthodontics in: Full – Monthly – Quarterly**

**Pays: Automatically – As Billed**

**Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS# of the Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth Date of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby give permission to bill my insurance company for services rendered by**

**Christine K. Abenoja, D.M.D., M.S.**

**I have read and understood the above policies and acknowledge my responsibilities.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name (Please Print) Insured (Signature) Date**