

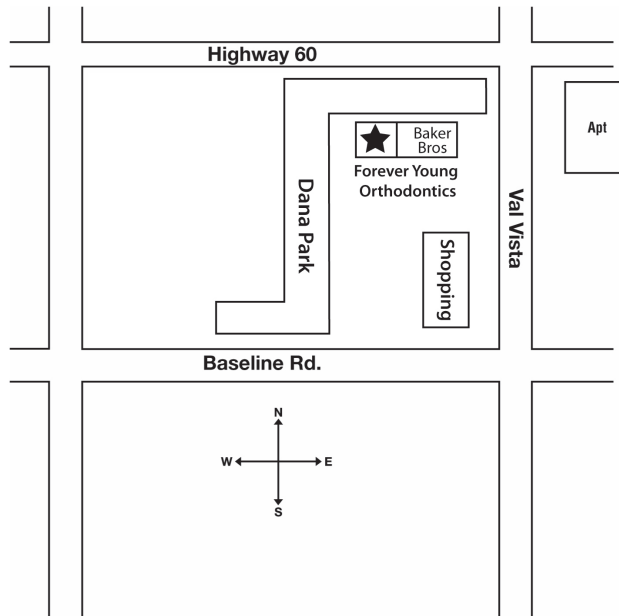


## NEW PATIENT WELCOME LETTER

Thank you for contacting FOREVER YOUNG ORTHODONTICS for your complimentary orthodontic consultation! Our contemporary, state-of-the-art office is located in beautiful DANA PARK RETAIL CENTER just south of Interstate 60 on the west side of Val Vista. We offer appointment times to fit most lifestyles and strive to provide each of our patients with personal attention and excellent results!

On your first visit Dr. Young will provide a comprehensive clinical examination including x-rays, address your personal concerns regarding your teeth and jaws, and propose a treatment plan that will have you on your way to a beautiful new smile. THE INITIAL VISIT AND CONSULATION ARE COMPLIMENTARY. We offer a variety of convenient payment options, submit to all insurances, and operate interest-free with no down payment!

Below you will find a map to our office. A HIPPA Form (which is your right to privacy), Insurance Form, and Medical History Form are also enclosed. Please bring these completed forms with you to your appointment. We look forward to meeting you on \_\_\_\_\_ at \_\_\_\_\_ and working together to create your beautiful new smile!



Cordially,

Dr. Ryan Young and Staff



## HIPPA FORM

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.

- Your protected health information (i.e., individually identifiable information, such as names dates, phone/fax numbers, email addresses, home addresses, social security numbers and demographic data) may be used or disclosed by us in one or more of the following respects;
- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the result of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification licensure or accreditation;
- Internally, to all staff members who have any role in your treatment.
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or
- 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 disclosures of your health information will be made after obtaining your written authorization, which you may revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services, which must be filed within 180 days of the violation.

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide notice of the change;

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

Privacy Authorization

This Authorization is required by the privacy regulations recently promulgated by the United States Department of Health and Human Services.

Your protected health information, including individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, demographic data, photographs, x-rays, study models, and health history forms will be used or disclosed for the purpose of: Lectures/presentations; Research; Teaching purposes; Board Certification

The following people will disclose this information: the staff and doctor

The information will be disclosed to the following people entities: the staff and doctor, dental/orthodontic board

You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on. If your treatment will be used for research purposes, we may condition your treatment on obtaining the Authorization, in which case you may not receive treatment. I hereby acknowledge that I have reviewed a copy of this Privacy Notice and the information used or disclosed per this Privacy Authorization may be subject to re-disclosure by the recipient(s), and this, no longer protected by the privacy rules.

\_\_\_\_\_  
Responsible Party and Date

\_\_\_\_\_  
Patient's Name and Date



Patient's Full Name:	Date of Birth:	Age:   M / F
Age at onset of puberty:	Physician's Name / Phone:	Date of Last Visit:
Are you currently under a doctor's care. If yes, why?		
Please list all of the medications you are currently taking:		
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name/phone/relationship of contact in case of emergency:	

### MEDICAL HISTORY FORM

*Do you have allergies to any of the following?*

Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Pills (Codeine) <input type="checkbox"/> Yes <input type="checkbox"/> No	Latex <input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No	Tetracycline <input type="checkbox"/> Yes <input type="checkbox"/> No	Metals/Other

*Have you ever had any of the following diseases or medical problems?*

Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Defect <input type="checkbox"/> Yes <input type="checkbox"/> No	Severe/Freq Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions/ Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	High/Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/ Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers/ Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery/ Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia/ Radiation Trx <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV+/ AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital stays - not pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/ Liver Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Difficulty <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Other:
Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Bones Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Doctor's Initials:

*I attest that the above medical history is accurate and authorize Dr. Young and staff to take diagnostic radiographs so as to determine an appropriate diagnosis and treatment plan.*

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Date



## PERSONAL INFORMATION AND INSURANCE FORM

PERSONAL INFORMATION					
Patient's Name:		Father's Name:		Mother's Name:	
Patient's Address:		Father's Address:		Mother's Address:	
Patient's Home Phone #:		Father's Home Phone #:		Mother's Home Phone #:	
Patient's Cell Phone #:		Father's Cell Phone #:		Mother's Cell Phone #:	
Patient's Work Phone #:		Father's Work Phone #:		Mother's Work Phone #:	
Preferred Name: (if any)		School Patient Attends:		Responsible Party e-mail:	
Dentist's Name / Phone:		Date of Last Visit:		How did you find out about us?	
SUBSCRIBER INFORMATION FOR PRIMARY INSURANCE					
Subscriber's Name:			Subscriber's S.S.N.:		
Birth Date:		Group ID#:		Group Name:	
Patient's relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Employer:		Employer Phone:		Employer Address:	
PRIMARY INSURANCE INFORMATION					
Insurance Company Name:					
Address:			City:	State:	ZIP Code:
Phone: (    )			Lifetime Maximum Benefit:		Used:
Payable at:                    %		Effective Date:	Pays:    Monthly or Quarterly		Pays:    Automatically / As Billed
SUBSCRIBER INFORMATION FOR SECONDARY INSURANCE (IF APPLICABLE)					
Subscriber's Name:			Subscriber's S.S.N.:		
Birth Date:		Group ID#:		Group Name:	
Patient's relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Employer:		Employer Phone:		Employer Address:	
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)					
Insurance Company Name:					
Address:			City:	State:	ZIP Code:
Phone: (    )			Lifetime Maximum Benefit:		Used:
Payable at:                    %		Effective Date:	Pays:    Monthly or Quarterly		Pays:    Automatically / As Billed