GREAT SMILES
PEDIATRIC DENTISTRY & ORTHODONTICS
CRYSTAL L. ANGELOPOULOS DMD | CHRISTOPHER S. HYDO DDS, MS | NATALIE G. MILLER DDS, MS

WELCOME TO OUR OFFICE!

We appreciate the opportunity to provide you with an orthodontic evaluation. Our treatment philosophy is to deliver the finest in orthodontic care while making the treatment an enjoyable and positive experience. We love creating beautiful smiles and strive to exceed patient expectations.

In order for us to become better acquainted, you will find a Health History Form, Responsible Party Form, HIPAA Form and Welcome to Our Practice form. Please complete these forms as they will help us better meet your specific orthodontic needs.

Welcome to the family!

Sincerely,
Drs. Hydo, Miller and Team

CARLSBAD
6010 HIDDEN VALLEY RD., SUITE 100
CARLSBAD, CA 92011
PHONE: 760.944.5115
FAX: 760.944.5226

SOLANA BEACH
530 LOMAS SANTA FE DR., SUITE H
SOLANA BEACH, CA 92075
PHONE: 858.755.4223
FAX: 858.755.3976

WWW.GREATSMILES.ORG

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PEDIATRIC DENTISTRY & ORTHODONTICS

CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home phone _____ Birthdate _____ SS# _____

If patient is a minor, give parent/guardian name _____

Whom may we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Email Address _____

Home phone _____ Work phone _____ Cell phone _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. years employed ____

Spouse's Name _____ Relationship to patient _____
Last First Middle

Employer _____ Occupation _____ No. years employed ____

Social Security # _____ Birthdate _____ Work phone _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ SS# _____

Policy Holder's Date of Birth _____ Relationship to Patient _____

Policy Holder's Address _____ Home Phone _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name _____ SS# _____

Policy Holder's Date of Birth _____ Relationship to Patient _____

Policy Holder's Address _____ Home Phone _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____

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PATIENT INFORMATION FORM

The information requested below is very important. Please make it as complete and accurate as possible because it will help us provide the best possible health service. This information form becomes part of our permanent records and will be held in strict confidence. For parents of children, complete this information for your child. Thank you for your cooperation.

PERSONAL Name of Patient: _____ Date of Birth: _____
Age: _____ Sex: _____ Is the patient adopted? YES NO Does the patient know? YES NO

FAMILY Is there anything we should know about the patient's family and/or their medical history? YES NO

_____

_____

MEDICAL 1. Patient's Physician: _____ Phone No: _____
2. Date of last medical exam: _____ Height: _____ Weight: _____
3. Does the patient have a current medical problem? YES NO _____

4. Is the patient taking any medications at this time? YES NO If yes, please circle:

YES NO Antibiotics YES NO Anti-convulsant YES NO Cortisone/steroids YES NO Antihistamines
YES NO Anticoagulants YES NO Pain Medication YES NO Thyroid hormones YES NO Insulin
YES NO Tranquilizers YES NO Birth Control Pills YES NO Anti-inflammatory YES NO High Blood Pressure

What type and dosage? _____
Any other medications? _____

5. Any <u>past</u> history of the patient taking the above medications? YES NO
6. Has the patient had any unfavorable reactions to the following drugs?

YES NO Penicillin YES NO Aspirin YES NO Erythromycin
YES NO Ibuprofin YES NO Codeine YES NO Local Anesthetics
YES NO Other: _____

7. Does the patient have a history of: Allergies? YES NO Mouth breathing? YES NO
8. Is the patient pregnant now? N/A NO YES Due date: _____
9. Has the patient had any of the following diseases or conditions? Please circle YES or NO and indicate approximate age:

YES NO Measles Age _____ YES NO Whooping cough Age _____
YES NO Chicken pox Age _____ YES NO Broken bones Age _____
YES NO Mumps Age _____ YES NO Serious accidents Age _____
YES NO Pneumonia Age _____ YES NO German (3-day measles) Age _____
YES NO Scarlet Fever Age _____ YES NO Rheumatic Fever Age _____
YES NO Removal of tonsils and adenoids Age _____

10. If the patient has had any history of the following, please circle YES or NO.

YES NO Hearing difficulties YES NO Skin Problems YES NO Speech difficulties
YES NO Epilepsy or seizures YES NO Emotional difficulties YES NO Cerebral Palsy
YES NO Poor Vision YES NO Sinus problems YES NO Diabetes
YES NO Breathing problems YES NO Liver disease/hepatitis YES NO Birth defects
YES NO Tumor/Cancer YES NO Heart problems/murmur YES NO Blood problems
YES NO Blood transfusion YES NO Bone/joint problems YES NO Major surgery
YES NO Kidney disease YES NO Herpes virus YES NO Head/neck pain
YES NO Frequent headaches YES NO Autoimmune disorders YES NO Ulcers
YES NO Fainting/Dizziness YES NO Disease(s) affecting normal growth

11. Any other condition not mentioned above? _____

12. Does the patient have any jaw problems? YES NO _____

YES NO Clicking of the jaw
YES NO Pain (joint, ear, side of face)
YES NO Difficulty opening/closing/chewing
YES NO Stiff jaw on awakening
YES NO Jaw stuck open or closed
YES NO Clenching or grinding teeth

DENTAL HISTORY

1. Patient's dentist: _____ City: _____ Phone: _____

2. Date of last dental visit: _____ Last dental xrays: _____

3. Please describe orthodontic problem: _____

4. Does anyone else in the family have a similar problem? _____

5. Has the patient had other orthodontic treatment in the past? _____

6. Orthodontist's name: _____ City/State: _____

7. Has anyone else in the family had orthodontic treatment? YES NO _____

8. How do you think the patient will react to orthodontic treatment?

Excellent Good Fair Poor I don't know

9. Does the patient have any of the following oral problems?

YES NO High decay rate YES NO Poor oral hygiene YES NO Malformed teeth
YES NO Neglect of gums YES NO Missing teeth YES NO Extra teeth
YES NO Developmental "white spots" on teeth YES NO Other: _____

10. How frequently does the patient brush his/her teeth? _____
11. Do the patient's gums bleed while brushing? YES NO
12. Have the patient's teeth ever been injured? YES NO
    What was the cause of the accident? _____
    What age was the patient at the time of the accident? _____
    Which teeth were involved? _____
13. Has the patient ever had: Periodontal surgery? YES NO Oral surgery? YES NO
14. Does the patient have any of the following habits?

YES NO Lip sucking YES NO Nail biting YES NO Thumb/finger sucking
YES NO Tongue thrusting YES NO Lip biting YES NO Grinding
YES NO Mouth breathing

15. Has the patient had any unfavorable experiences in a dental/medical office? YES NO
    If yes, please describe: _____

OTHER

Is there any other information that you believe would be helpful to us? If yes, please comment: _____

Does the patient have any disease, condition or problem that is not mentioned above? If yes, please explain: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Address _____
Phone _____ Relationship to patient _____

CONSENT: To the best of my knowledge, the above answers are true and correct. If I have any change in my health, I will inform my doctor at the next appointment. The undersigned hereby authorizes the patient to have radiographs, study patient's dental needs.

Signature:_____ Relationship to patient: _____ Date:_____

GREAT SMILES
PEDIATRIC DENTISTRY & 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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 this Notice, please contact us using the information listed.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

o Prevent or control disease, injury or disability;

o Report child abuse or neglect;

o Report reactions to medications or problems with products or devices;

o Notify a person of a recall, repair, or replacement of products or devices;

o Notify a person who may have been exposed to a disease or condition; or

on Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or

administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Officials: Christopher Hydo & Crystal Angelopoulos
Telephone: (858) 755-4223 Address: 530 Lomas Santa Fe Drive Suite H, Solana Beach, CA 92075
E-mail: orthodontics@greatsmiles.org or pediatricdentistry@greatsmiles.org

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PEDIATRIC DENTISTRY & ORTHODONTICS

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* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

GREAT SMILES

PEDIATRIC DENTISTRY & ORTHODONTICS

Carlsbad 760.944.5115 Solana Beach 858.755.4223

PATIENT PHOTOGRAPH AND TESTIMONIAL AUTHORIZATION FORM

I hereby give my consent for **Great Smiles Pediatric Dentistry & Orthodontics** to take photographs, slides and/or videotape of *(Print full name of patient)* _____ face, jaw, and teeth. I understand that some of these images may be used by laboratories for fabrication of appliances, retainers, or Invisalign trays/retainers and these images will become part of the patient record.

If I have provided a written testimonial about my experience with **Great Smiles Pediatric Dentistry & Orthodontics**, the testimonial may be used in whole or in part as indicated below.

Please circle "do" or "do not" for each statement, and initial.

I	do	do not	consent to the use of these images in professional articles and presentations.	_____
I	do	do not	consent to the use of these images within the dental practice to be seen only by individuals who walk into the practice.	_____
I	do	do not	consent to the use of these images to promote the dental practice through various media, including but not limited to print advertising, brochures, and the Internet.	_____

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise, from **Great Smiles Pediatric Dentistry & Orthodontics**. I hereby release and discharge **Great Smiles Pediatric Dentistry & Orthodontics** from any and all claims and demands arising out of or in connection with the use of my name, photograph, personal testimonial, or other information provided by me, including any and all claims for libel and invasion of privacy.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

_____

Print Patient's or Legal Guardian's/Representative's Name

_____ _____

Patient's or Legal Guardian's/Representative's Signature Date

WELCOME TO OUR OFFICE

My name is...

_____

_____

But you can call me...

_____

_____

In my spare time I like to...

_____

_____

_____

Do you have any friends that come to our office? What are their names?

_____

_____

_____

Do you have any pets? What are their names?

_____

_____

_____

Which school do you go to?

_____

_____

The things I like best about school are...

_____

_____

Tell us something special about yourself that you would like to share.

_____

_____

_____

My favorite kind of music, singer or group is...

_____

_____

_____

I think that having braces would be...

_____

_____

_____