HULSE
ORTHODONTICS

ADULT FORM

Thank you for providing this important information to help us serve you the best. If you have any questions or need assistance, just ask. ***We're happy to help!***

Patient Information

PREFERRED APPOINTMENT CONFIRMATION EMAIL ☐ TEXT ☐ CELL PROVIDER _____

NAME _____ PREFERRED NAME _____

DATE OF BIRTH _____ GENDER _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____

HAVE WE TREATED ANY FAMILY MEMBERS? IF YES, WHO? _____

HOW DID YOU HEAR ABOUT US? ☐ DENTIST ☐ PATIENT ☐ GOOGLE ☐ INSURANCE ☐ INVISALIGN ☐ SCHOOL ☐ FAMILY ☐ STAFF ☐ SIGN

IF PATIENT, WHO? _____

MARITAL STATUS ☐ MARRIED ☐ DOMESTIC PARTNER ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

Spouse/Partner Information

NAME _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

CELL PHONE _____ EMAIL _____

Primary Insurance Information

☐ CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Secondary Insurance Information

☐ CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Emergency Contact Information

NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____ CELL PHONE _____

Medical History

PHYSICIAN _____

DATE OF LAST EXAM _____

	Y	N
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS?	☐	☐

IF YES, WHAT?

_____

_____

3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐

IF YES, WHAT MEDICATION(S) ARE YOU TAKING?

_____

_____

4. DO YOU USE TOBACCO?	☐	☐
5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS/LATEX?	☐	☐

IF YES, WHAT?

_____

_____

6. FEMALES ONLY: ARE YOU PREGNANT, OR THINK YOU MAY BE?	☐	☐
7. HAVE YOU EVER TAKEN BISPHOSPHONATES (EX:FOSAMAX) FOR OSTEOPOROSIS?	☐	☐

IF YES, SPECIFY _____

8. PLEASE CHECK ALL THAT APPLY:

AIDS OR HIV INFECTION	☐	HIGH/LOW BLOOD PRESSURE	☐
ALLERGIES	☐	KIDNEY/LIVER DISEASE	☐
ANEMIA	☐	LEUKEMIA	☐
ASTHMA (INHALER)	☐	OSTEOPENIA/OSTEOPOROSIS	☐
BONE DISORDER	☐	RADIATION THERAPY	☐
CANCER	☐	RESPIRATORY PROBLEMS	☐
DIABETES	☐	RHEUMATIC FEVER	☐
EPILEPSY/CONVULSIONS	☐	SINUS PROBLEMS	☐
FAINTING/SEIZURES	☐	STOMACH TROUBLES/ULCERS	☐
HEADACHES	☐	STROKE	☐
HEART TROUBLE	☐	THYROID PROBLEM	☐
HEPATITIS/JAUNDICE	☐	OTHER: _____	☐

Dental History

DENTIST _____

DATE OF LAST CLEANING _____

	Y	N
1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT?	☐	☐
2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT?	☐	☐
3. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐
4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	☐	☐

IF YES, PLEASE DESCRIBE:

_____

6. DO YOU HAVE ANY ONGOING PROBLEMS WITH YOUR JAW?	☐	☐

IF YES, PLEASE DESCRIBE:

_____

7. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
8. HAVE YOU EVER HAD SPEECH THERAPY?	☐	☐

IF YES, PLEASE DESCRIBE:

_____

9. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED?

IF YES, PLEASE DESCRIBE:

_____

	Y	N
10. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:		
A. NAIL BITING?	☐	☐
B. THUMB SUCKING?	☐	☐
C. TONGUE THRUST WHILE SWALLOWING?	☐	☐
D. MOUTH BREATHING?	☐	☐

11. WHAT IS YOUR MAIN CONCERN FOR TODAY'S VISIT:

_____

_____

_____

12. HAVE YOU EVER HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE?	☐	☐

IF SO, WHEN AND BY WHOM?

_____

13. HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS: PERIODONTAL TREATMENT, ENDODONTIC TREATMENT, ORAL SURGERY, PROSTHODONTIC TREATMENT?	☐	☐

IF SO WHAT AND WHEN?

_____

Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO MY MEDICAL STATUS. I GIVE HULSE ORTHODONTICS PERMISSION TO PERFORM AN ORTHODONTIC EXAMINATION AND EVALUATION.

PRINT NAME _____

☐ I ALLOW HULSE ORTHODONTICS TO COMMUNICATE WITH ME VIA PHONE, TEXT, AND EMAIL

SIGNATURE

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 IT CAREFULLY.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit Hulse Orthodontics, 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 Practice describes how Hulse Orthodontics may use and disclose your information and the rights 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 Dr. Hulse 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. Dr. Hulse will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations', so Dr. Hulse will know how you are responding to treatment. We will also provide your physician, or 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 records to access 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 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 indentify, 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.
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 recalls, repairs or replacement.
Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary, to comply with the 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 activities, such as audits and investigations necessary for oversight of the health care system and government benefits programs.
Judicial and Administrative Proceedings: We may disclose your health information in a judicial or administrative proceeding if the request for 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 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 treatment 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 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 service 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 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 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 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 a breach of your unsecured health information.
- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

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