Smile Today Orthodontics
MEDICAL HISTORY REGISTRATION and HIPAA

Group Practice of Orthodontists Dr. Vincent Bilello and Dr. Evanthia Peikidis
Glenridge Orthodontics 65-34 Myrtle Avenue, Glendale, New York 11385, (718) 386-8728
Smile Today Orthodontics 64 New Hyde Park Road, Garden City NY 11530, (516) 265-1536
www.SmileTodayOrthodontics.com Email: info@glenridgeorthodontics.com

Thank you for choosing our practice. If you have any questions, we will love to help you.

Today's Date: _____/_____/_____ **(Please Print)**

Patient Information

Name:_____Date of Birth: ____/____/_____ Sex: M / F
Last First Middle

Home Address: _____City:_____State:_____ Zip Code:_____

Cell Phone (____)_____-_____ Home Phone (____)_____-_____ Work/Other (____)_____-_____

Email, Used only for Appointment Reminders:_____@_____._____ *Email*

How did you hear about us? _____

General Dentist Name:_____ General Dentist Phone number: (____)_____-_____

Address or Location:_____ Please look up location online if you aren't sure

Date last seen for cleaning/checkup by your general dentist: Month: _____ Year:_____

All orthodontic patients must see their general dentist within 6 months before orthodontic treatment.

Responsible Party (Fill in any missing information *if patient is under 18 years of age)*

Name:_____ _____ Date of Birth: ___/____/_____
Last First

Relationship to Patient: _____ E-mail: _____

Address *(if different from patients):* _____City:_____State:_____ Zip Code:_____

Home Phone (____)_____-_____ Cell Phone (____)_____-_____ Work Phone (____)_____

Dental Insurance

Subscriber's Name: _____ Date of Birth: ___/____/_____
Last First

Relationship to Patient: Self / Mother / Father/ Spouse / Other:_____

Insurance Company #1: _____UnionPlan:_____Group/Policy #: _____

Do you have Medicaid with your insurance? Yes / No If yes, what is the Medicaid ID #_____
Insurance Company #2:_____ Subscriber's Name_____ DOB____/____/_____

Your Initial Orthodontics Consultation is complimentary. There is no charge for this visit or photos/x-rays taken. We will have patients sign an Insurance form to find out coverage only, we will not bill your private insurance for this visit. All orthodontic fees will be given to patients in writing before any work is done. We will bill out the insurance only when we agree on a fee to start treatment. Orthodontic treatment requires preauthorization that may take at least a month to get approval for. I acknowledge that if orthodontic treatment is started at this location and for any reason my insurance is terminated, I am responsible for any unpaid amount towards the agreed upon contract. If the coverage is terminated during orthodontic treatment, new financial agreements must be made to continue orthodontic treatment.

Date: ____/____/_____

Signature of Parent/Guardian, or patient when 18yrs or older: _____

Medical History

1. Are you under a physician's care now dealing with a medical issue? No / Yes If so, please give reason for treatment: _____
2. Are you taking any kind of medication at this time? No / Yes If so, what kind?

   _____
3. Please circle any illnesses you have ever had

Allergies (List):_____

Diabetes: Type I (requires insulin) / Type II (insulin resistance) Rheumatic fever

Epilepsy Heart Trouble Heart Surgery Glaucoma

High Blood Pressure Low Blood Pressure Kidney or Liver Tuberculosis

Asthma Acquired Immune Deficiency Syndrome/HIV Positive Hep C Infectious Hepatitis

If you would like to tell only the doctor about your condition, please let the doctor know directly.

4. Are you pregnant? No/ Maybe (trying to conceive)/ Yes We will avoid taking x-rays for patients that may be pregnant.

   If pregnant, Congratulations, how many months?_____ Due Date? ____/____/_____
5. Have you ever had prolonged bleeding after surgery? No / Yes_____
6. Do you have any bleeding issues or blood disorders? No / Yes _____
7. Have you ever had any unusual reaction to an anesthetic like Lidocaine? No / Yes _____
8. Have you had any unusual reaction to a drug (like penicillin)? No / Yes _____
9. Do you have to be pre-medicated (antibiotics) before dental procedures? YES / NO If yes, Explain what kind of medication/dose and what condition it is for:_____

   _____

   Your cardiologist will need to give us a letter on what your exact condition is/needs are.

   Have your cardiologist provide you with a PREVENTION OF INFECTIVE (BACTERIAL) ENDOCARDITIS Wallet Card
10. Are you Allergic to Latex? No / Yes We use only non latex gloves, but some ortho elastics are latex
11. Do you have any allergies? No / Yes Explain:_____
12. **When dental impressions are taken do you gag?** No/Yes_____
13. Is there any other information that should be known about your medical or dental health?

    _____
14. Does your Temporomandibular Joint (TMJ) Click when you open?_____
15. Do you have pain in your TMJ when you open or close?_____
16. Does your TMJ Ever lock in an open position? _____ Closed Position? _____

_____ _____

Signature *of Patient or Parent/Guardian if patient is under 18 years of age* *Date:*

Before 4 pages are scanned in, staff to fill out below:

For Staff: Collected all patient information & entered into computer, Reviewed Doctor Resume, Office policies and scanned in sheet: _____

Smile Analysis

Your smile affects your self-image, and can greatly influence the quality of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable with their smile. You don't have to be a dentist to know if something just doesn't look right. The following questions are designed to honestly appraise your smile. Go to a mirror, smile as wide as you can, and ask yourself the following questions:

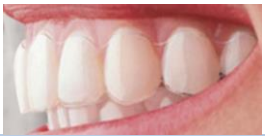
Are any of your teeth yellow, stained or somewhat discolored?		Yes	No	Maybe
Would you like your teeth to be whiter? *We offer in house whitening options to our orthodontic patients after treatment.*		Yes	No	Maybe
Do you have any gaps or spaces between your teeth? *Sometimes a fixed lingual retainer after treatment will be needed along with a removable retainer to keep closed large spaces.*		Yes	No	Maybe
Are any of your teeth turned, crooked, or uneven? *Crooked teeth are harder to clean and are more prone to cavities and gum disease.*		Yes	No	Maybe
Are you missing any adult (permanent) teeth? *Replacing missing teeth balances your bite keeping your smile straight longer.*		Yes	No	Maybe
Do you see any pitting or defects on the surfaces of your teeth? *White or dark spots can be congenital or they can be formed from plaque bacteria.*		Yes	No	Maybe
Are the edges of any teeth worn down, chipped or uneven? *Those teeth may need composite added to restore shape, or enamel-plasty or composite restorations.*		Yes	No	Maybe
Do any of your teeth appear too small, short, large or long? *You may need to modify the size of the teeth before or after orthodontic treatment with your general dentist.*		Yes	No	Maybe
Do you have any prior dental work that appears unnatural?		Yes	No	Maybe
Do you have any crowns or bridges that appear dark at the edge of your gums?		Yes	No	Maybe
Do you have any metal crowns or silver fillings in your teeth?		Yes	No	Maybe
Do you have a "gummy" smile (too much of your gums show when smiling)?		Yes	No	Maybe
Are your gums red, sore, puffy, bleeding or receded? *You will need to see a general dentist before starting orthodontic treatment as gum disease can get worse if not fully cared for by your general dentist or periodontist.*		Yes	No	Maybe
Does the appearance of your smile inhibit you from laughing or smiling?		Yes	No	Maybe
When being photographed, do you smile with your lips closed instead of flashing a full smile?		Yes	No	Maybe
Are you self-conscious about your teeth or smile?		Yes	No	Maybe
Would you like to change anything about the appearance of your teeth or smile?		Yes	No	Maybe
Did you know that straighter teeth can improve their function and increase chewing efficiency? *Besides the cosmetic benefits of straight teeth, we as Orthodontists balance your occlusion for best function. This usually results in less TMJ pain later in life.*		Yes	No	Maybe

What bothers you most about your teeth, what do you want to fix?

Write here:_____

If you answered YES to ANY of the questions above, there are often several alternatives to improve your teeth and smile.

To straighten your teeth the orthodontist has different options.
Which options would be most interested in?
(Circle which ones you are considering)



1. **Traditional Braces with silver ties:** *Today's metal braces are noticeably smaller than long ago. They have silver elastic ties around them.*
2. **Traditional Braces with Colors:** *Have colored elastic ties around them instead of silver.*
3. **Ceramic Braces (Clear Braces):** *Clear ceramic brackets (usually on the top teeth only) blend more naturally into your teeth. Sometimes we can use tooth-colored wires.*
4. **Invisalign:** *Consists of a series of customized, clear BPA-free plastic tray aligners that are removable and typically replaced every week to keep your teeth moving in the desired direction.*

Health Insurance Portability and Accountability Act: Patients, Parents, Friends & Family of Orthodontic Patients

There is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it. By law, your health information can be used and shared for specific reasons not directly related to your care, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information. Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You can ask that your health information not be shared with certain people, groups, or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. You can make reasonable requests to be contacted at different places or in a different way. For example, you can ask to have a nurse call you at your office instead of your home or to send mail to you in an envelope instead of on a postcard. Your photos will not be posted on our website or social media pages. The patient/parent may post their own photos online about their treatment if they would like to. We use password protected computer systems to protect patient data. All patient information is not shared to anyone unless patient/parent fully agree to such sharing of records to another party. We practice in a semi-private treatment room environment, some of our treatment areas are open bay where other patients may hear and see what we are talking about regarding treatment. If there is more than one chair in a large room, this is what we consider open bay. We do this to streamline treatment and reduce wait times. Hospitals also practice in such an environment. Please let us know if you require a private treatment area for you as this may require special scheduling. We can also set an alert for your chart any privacy preferences that you may have.

I understand the statements on this page

_____ _____/_____/_____

Signature of Patient if 18yrs or older or Responsible Party Today's Date

_____

Print patient name or parent name if patient under 18

Please provide us with a Photo ID of the Adult responsible for the patient.

When under the age of 18yrs of age a new patient is required to be accompanied by their parent until a treatment plan has been formulated. The doctor's and staff welcome questions from the parents involving the patient's treatment. We require that there be no personal cell phone conversations throughout the office (in the reception/lounge area and treatment area) to keep noise level down for the comfort of all. Any distractions to the doctor/staff treating a patient will require those distractions to wait in the lounge area or outside. Future appointments may not require the presence of the parents. We will always contact the parents if there are any problems with treatment. We encourage that if the parents/patients have questions about their treatment, to address them with the doctor before that treatment visit, after which parents/friends may wait in the reception area. The doctor will always be available to speak to parents personally if needed at any time before or after the treatment. Phone calls to the parents regarding clinical/treatment questions will be made upon request. *All patient information is not shared to anyone unless patient/parent fully agree to such sharing of records to another party. If requested we will provide your insurance company with any records they request.* For more information, go to the link below:

https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"