Welcome to

BEAVERTON ORTHODONTICS

Tarim S. Song, DDS, MS, LLC
Specialist in Orthodontics for Children & Adults

Patient Information

Last Name _____ First Name _____
Preferred Name/Nickname_____ Birthdate _____
Gender assigned at birth: ☐ F ☐ M ☐ prefer not to say Preferred pronoun: ☐ she/her ☐ he/him ☐ they/them
Address _____ City _____ Zip Code _____
School _____ Grade _____
Who is accompanying the patient today? _____ Relationship to patient _____
Other family members treated here _____
Whom may we thank for referring you to our office? _____
What is the reason for your visit today? _____

Responsibility Party #1

Name of Responsible Party _____ Relationship to Patient _____
Residence *(if different from above):* _____
Cell Phone _____ Work Phone _____ Email _____
Preferred method(s) for appointment reminders: ☐ Text message ☐ Phone call ☐ Email
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic partnership
If divorced/separated, patient lives with ☐ Mom ☐ Dad ☐ Other _____
Occupation _____ Employer _____

Responsibility Party #2 *(if applicable)*

Name of Responsible Party _____ Relationship to Patient _____
Residence *(if different from above):* _____
Cell Phone _____ Work Phone _____ Email _____
Preferred method(s) for appointment reminders: ☐ Text message ☐ Phone call ☐ Email
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic partnership
Occupation _____ Employer _____

Orthodontic Dental Insurance Information

Policy Holder's Name _____ Birthdate _____ Relation to Patient _____
Social Security # _____ Employer _____
Insurance Company _____ Insurance Co Phone _____
Ins Group # _____ Ins ID # _____

Secondary Orthodontic Dental Insurance *(if have dual coverage):*

Policy Holder's Name _____ Birthdate _____ Relation to Patient _____
Social Security # _____ Employer _____
Insurance Company _____ Insurance Co Phone _____
Ins Group # _____ Ins ID # _____

I release any information needed and authorize insurance payment directly to Tarim Song, DDS, MS, LLC of Beaverton Orthodontics, the benefits otherwise payable to me.

Parent/Guardian Signature _____ Date _____

HEALTH HISTORY

Physician/Hospital _____ Date of last visit _____

Has the patient been under the care of a physician during the past two years? _____

Please check Yes or No (If Yes, please provide details)

- ☐ Yes ☐ No Taking any medications/drugs? _____
- ☐ Yes ☐ No History of major illness or hospital stay? _____
- ☐ Yes ☐ No Surgeries? _____
- ☐ Yes ☐ No Tobacco use? _____

Female patients only:

- ☐ Yes ☐ No Has menstruation started? If Yes, indicate Month/Year of menarche (first period) _____
- ☐ Yes ☐ No Currently pregnant? If Yes, approximate delivery date _____

Confirmed Allergies ☐ Acetaminophen ☐ Aspirin ☐ Ibuprofen ☐ Latex ☐ Nickel ☐ Lactose intolerance

Other allergies (please explain)_____

Check any of the medical conditions below that your child had or currently has (or check NONE OF THE ABOVE):

- ☐ Asthma/lung problem
- ☐ Attention/behavioral disorder
- ☐ Blood disorder (e.g. anemia)
- ☐ Bone disorder/osteoporosis
- ☐ Cancer/tumor/radiation/chemo
- ☐ Congenital syndrome
- ☐ Diabetes (Type: _____)
- ☐ Drug/alcohol abuse
- ☐ Eating disorder (e.g. bulimia)
- ☐ Epilepsy/seizures/fainting
- ☐ Gastrointestinal disorders
- ☐ Headaches/migraines
- ☐ Heart problems
- ☐ High/low blood pressure
- ☐ Liver problems/hepatitis
- ☐ Herpes/fever blisters
- ☐ HIV/AIDS
- ☐ Immune system problems
- ☐ Psychiatric/mental illness (e.g. anxiety)
- ☐ Sleep-related breathing disorder
- ☐ Sexually transmitted disease
- ☐ Thyroid/endocrine problems
- ☐ Tonsil/adenoid condition
- ☐ Tuberculosis
- ☐ **NONE OF THE ABOVE**

If Yes to any of the above conditions, please explain: _____

Other medical conditions?_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

- ☐ Yes ☐ No Is there any unfinished dental care to be completed? _____
- ☐ Yes ☐ No Aware of lost, chipped, missing or extra adult teeth? _____
- ☐ Yes ☐ No Significant injury to face, jaw, mouth, or teeth? _____
- ☐ Yes ☐ No Do the gums bleed when brushing? _____
- ☐ Yes ☐ No Is there a thumb/finger sucking habit or tongue thrust? _____
- ☐ Yes ☐ No Mouth breather? Awake and/or asleep? _____
- ☐ Yes ☐ No Ever seen an orthodontist? Who/When? _____
- ☐ Yes ☐ No Awareness of teeth clenching or grinding? _____
- ☐ Yes ☐ No Any TMJ pain or popping/clicking/noise? _____
- ☐ Yes ☐ No Musical instruments played? _____

AUTHORIZATION FOR ORTHODONTIC EVALUATION

I understand the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of changes in my child's medical or dental status. I authorize Tarim S. Song, DDS, MS to perform a complete orthodontic evaluation. I consent to receiving electronic appointment reminders and can opt-out at any time by text, email, or voice.

Signature _____ Date _____

Child

BEAVERTON 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.

Our Legal Duty. We are required to maintain the privacy of your Protected Health Information (PHI). We are also required to provide you this Notice and follow the practices that are described herein while this notice is in effect. This notice takes effect 4/16/12, and will remain in effect until we replace it. We may change our privacy practices and the terms of this notice, provided the changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and provide the new one at our practice location, and distribute it upon request. You may request a copy of this Notice at any time. For more information, please contact us at 503-524-0524.

Your Authorization. In addition to our use of your PHI as described below, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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 a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information

Treatment: We may use or disclose your PHI to provide, coordinate, or manage your health care/related services.
Payment: We may use and disclose your PHI to obtain payment for services we provide to you.
Healthcare Operations: We may use/disclose your PHI for healthcare operations, including quality assessment/improvement, reviewing competence or qualifications of healthcare professionals, evaluation practitioner/provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
Personal Representative: We must disclose your PHI to you. If you agree so, we may disclose PHI to your personal representative.
Persons Involved in Care: We may use or disclose PHI to notify or assist in the notification of a family member, your personal representative, or another person responsible for your care, of your location, general condition, or death. If you are present, then prior to use or disclosure of your PHI, we provide you with an opportunity to object. In the event of your absence or incapacity or in an emergency, we will disclose PHI based on a determination using our judgment and disclosing only information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up orthodontic supplies, x-rays, or other similar forms of PHI.
Disaster Relief: We may use or disclose your PHI to assist in disaster relief efforts.
Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization.
Required by Law: We may use of disclose your health information when we are required to do so by law.
Public Health and Public Benefit: We may use or disclose your PHI to report abuse, neglect, domestic violence; to report disease, injury, and vital statistics to the FDA; for health oversight activities; for certain judicial/administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.
Decedents: We may disclose PHI about a decedent as authorized or required by law.
National Security: We may disclose PHI of Armed Forces personnel under certain circumstances. We may disclose PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the PHI of an inmate of patient under certain circumstances.
Appointment reminders: We may use or disclose your PHI to provide you with appointment reminders such as voicemails, postcards, or letters.

Patient Rights

Access: You must request in writing to obtain access to your health information. You have the right to look at or receive copies of your health information, with limited exceptions. We will charge you a reasonable fee for copying expenses and staff time. To obtain a form to request access, contact our Office Manager or send us a letter to our office address.
Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI for the last 6 years, but not before April 14, 2003.
Restriction: You have the right to request restriction of disclosure of your PHI. Your request must be in writing and must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, but if we do, we will abide by our agreement (except in an emergency). We must comply with a request to restrict the disclosure of PHI to a health plan for purposes of payment or health care operations (as defined by HIPAA) if the PHI pertains solely to a healthcare item or service for which we have been paid out of pocket in full.
Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. Your request must be in writing. Your request must specify the alternative means/location, & provide satisfactory explanation of how payments will be handled under the requested alternative means.
Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically.

Questions and Complaints. If you want more information, or have questions or concerns, please contact our Office Manager/Compliance Officer. If you are concerned with our handling of your PHI, you may complain to our Office Manager/Compliance Officer at 503-524-0524. You may also submit a written complaint to the US Dept of Health and Human Services. We support your right to the privacy of your PHI, and we will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Print name: _____ Signature: _____ Date: _____
(Custodial/Responsible Party/Guardian) (Custodial/Responsible Party/Guardian)