PATIENT INFORMATION

WELCOME TO OUR OFFICE!

Date _____

Patient's Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *Zip*

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, parent or guardian's name _____

Patient: _____ Responsible Party: _____
Email Address *Email Address*

RESPONSIBLE PARTY INFORMATION

Name _____
Last *First* *Middle* *Marital Status*

Residence _____
Street *City* *State* *Zip*

Mailing Address _____
Street *City* *State* *Zip*

How long at this address _____ Cell Phone & carrier _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street *City* *State* *Zip*

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last *First* *Middle*

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue: _____
Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

EMERGENCY INFORMATION

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

How did you hear about our office? _____

Signature (Parent's signature, if minor) _____ Date _____
I understand that where appropriate, credit bureau reports may be obtained.

Medical & Dental History

Patient's Name (printed):_____

Dental History:

Patient's Dentist: _____ Dentist Phone: _____

Date of last cleaning & exam: _____

Any dental issues or changes noted at last exam? _____

_____

How often does the patient brush? _____ How often does the patient floss?_____

Does/Did The Patient: Grind his/her teeth at night? ☐ Yes ☐ No Suck thumb, finger, pacifier etc? ☐ Yes ☐No

If yes, at what age did this habit stop? _____

Medical History:

Patient's Physician: _____ Physician Phone: _____ Date of Last Exam: _____

Are you aware of any changes in the patient's medical history? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child have/had:	Yes	No		Yes	No
Birth Defect	☐	☐	Eye Disorder	☐	☐
Cleft Lip/Palate	☐	☐	Hearing Problems	☐	☐
Speech Difficulty	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Cystic Fibrosis	☐	☐
Blood Transfusion	☐	☐	Tuberculosis	☐	☐
Emotional Disorder	☐	☐	Developmental Disorder/Delay	☐	☐
Diabetes	☐	☐	Thyroid or Endocrine Disorder	☐	☐
Heart Disease	☐	☐	Heart Murmur or Heart Condition	☐	☐
Hepatitis or Liver Disease	☐	☐	Rheumatic Fever	☐	☐
Neurological Disorder	☐	☐	Epilepsy or Seizures	☐	☐
Anemia	☐	☐	Bleeding Disorder	☐	☐
Injury to Face/Teeth/Gums	☐	☐	Tonsil/Adenoid Surgery	☐	☐
Unfavorable Dental Experience(s)	☐	☐	Cold Sores	☐	☐
HIV Positive	☐	☐	Cancer	☐	☐
Females: Has started menstruation Age:	☐	☐	Males: Has undergone voice changes	☐	☐
Immunizations are up to date	☐	☐	Has the patient ever been advised to take antibiotics prior to a dental visit?	☐	☐

List any conditions not mentioned: _____

_____

List known allergies (medications, latex, etc): _____

_____

List current medications: _____

_____

Has the patient taken any oral or IV **bisphosphonate drug** (*such as Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos*? ☐ Yes ☐ No If yes, reason: _____

Parent/Guardian Signature: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**

This consent form allows Enbrite Dental- DBA Michigan Orthodontics to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Enbrite Dental- DBA Michigan Orthodontics has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Enbrite Dental- DBA Michigan Orthodontics.

_____ **Initial** I hereby authorize Enbrite Dental- DBA Michigan Orthodontics to use unsecured email and mobile phone test messaging to transmit to me the following protected health information: Information related to the scheduling of appointments; and, Information related to billing and payment.

_____ **Initial** I hereby authorize that Enbrite Dental-DBA Michigan Orthodontics may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____ Email _____ Home Phone _____ Office Phone _____ Cell Phone

_____ **Initial** I hereby authorize that Enbrite Dental- DBA Michigan Orthodontics may disclose my health information to any person(s) who accompany me to my appointment , and are present with me in the office while I meet with my dentist and staff.

_____ **Initial** I hereby authorize that Enbrite Dental- DBA Michigan Orthodontics may disclose my personal health information to the person who I have listed as my emergency contact.

_____ **Initial** I hereby authorize that Enbrite Dental- **DBA** Michigan Orthodontics may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Enbrite Dental - DBA Michigan Orthodontics services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Enbrite Dental - DBA Michigan Orthodontics may refuse service if I revoke this consent.

I understand that I have the right to request - now and in the future - how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Enbrite Dental- DBA Michigan Orthodontics is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor)
Authorized Representative _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Enbrite Dental (DBA Michigan
Orthodontics)
214 W, Michigan Avenue
Saline, Ml 48176
(734) 429-5433 office
{734) 429-5033 fax

Privacy Officer: Jonathan Dzingle

Effective Date: 12/5/20

THIS NOTICE DESCRIBES HOW DENTAL INFORM ATION ABOUT YOU MAY BE USED AND OISCLOSEO AND HOW YOU CANGET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and ore committed to maintaining the confidentiality of your medical/ dental Information. We make a record of the dental core we provide and may receive such records from others. We use these records to provide or enable other health core providers to provide quality dental care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. We ore 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. This notice describes how we may use and disclose your medico// dental Information. It also describes your rights and our legal obligations with respect to your medical/ dental information. If you hove any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Dental Practice May Use or Disclose Your Health Information

This dental practice collects health information about you and stores it in a chart [and/or on a computer][and in an electronic health record/personal health record]. This is your dental record. The dental record Is the property of this dental practice, but the information in the dental record belongs to you. The law permits *us* to use or disclose your health Information for the following purposes:

l. Treatment. *We* use medical/ dental information about you to provide your dental *care.* We disclose medical/ dental information to our employees and others who are involved In providing the care you need. For example, we may share your medical/ dental information with other dentists or other health care providers who will provide services that we do not provide Or we may share this information with a pharmacist who needs It to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical/ dental Information to members of your family or others who can help you when you are sick or Injured, or after you die.

2. Payment. *We* use and disclose medical/ dental information about you to obtain payment for the services we provide . For example, we give your health plan the Information It requires before It will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical/ dental Information about you to operate this dental practice. For example, we may use and disclose this information to review and improve the quality of care *we* provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your dental plan to authorize services or referrals . We may also use and disclose this information as necessary for dental reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical/ dental information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. *We* may also share your information with other health care providers, health care clearing houses or dental plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce **health care costs, their protocol development, case management or care-coordination** activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accredtation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical/ dental Information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message le ft with the person answeirng the phone.

S. Sign In Sheet. We may use and disclose medical/ dental Information about you by having you sign In when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist In notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your *care* or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection If we believe it Is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best Judgment In communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, healthcare providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or *service* when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that Is currently prescribed for you. *We* will not otherwise *use* or disclose your medical/ dental information for marketing purposes or accept any payment for other marketing communications without your prior written authorization . The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health Information without your prior written authorization. The authorization will disclose that we will receive compensation for your health Information If you authorize us to sell It, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but *we* will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. *We* may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or Infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require Informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial **proceeding to the extent expressly authorized by a court or administrative order. We may** also disclose Information about you in response to a subpoena, discovery request other lawful process If reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and Imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correction Institutions or law enforcement officers that have you In their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we may be required make periodic reports to your employer about your condition. We are also required by law to report cases of occupational Injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. in the event that this dental practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another dentist or dental group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. if you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods **as** appropriate. (Note: Only use e-mail notification if you are certain It will not contain PHI and It will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

B. When This Dental Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this dental practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this dental practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosure of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. if you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in **a** specific way or at a specific location. For example, you may ask that we send information to **a** particular e-mail account or to your work address. We will comply with all reasonable requests submitted In writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical/ dental information, you must submit a written request detailing what information you want access to, whether you **want to Inspect It or get a copy of it, and If you want a copy, your preferred form and** format. We will provide copies in your requested form and format If it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send **a** copy to any other person you designate In writing . We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your **health information that you believe is incorrect or incomplete You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or** incomplete. We are not required to change your health information, and will provide you with information about this dental practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, If we did not create the information (unless the person or entity that created the information Is no longer available to make the amendment), if you would not be permitted to inspect or copy the Information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision and we may In turn prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information .

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this dental practice, except that this dental practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this dental practice has received notice from that agency or official that providing this accounting would be reasonably likely to Impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

0. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this dental practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region 5 - Chicago (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)
Art Garcia (Acting!
Office for Civil Rights U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240 Chicago, IL 60601
Voice Phone (8001 368-1019
FAX (312) 886-1807
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

You will not be penalized in any way for filing a complaint.

COVID-19 Pandemic Dental Treatment Consent Form

I,_____knowingly and willingly consent to have dental treatment completed on during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms but may still be contagious.

I understand that what is currently known about the COVID-19 that the spread is thought to occur mostly from person-to-person via respiratory droplets when in close contact.

I understand that the unknowns of the virus, the procedures that have been performed in the practice along with the number of patients that have been here, that I have an increased risk of contracting the virus by receiving treatment in the practice or by being in the practice.

I understand that the symptoms listed below represent COVID-19:

- Fever
- Shortness of Breath/Difficulty Breathing
- Dry Cough
- Temperature 100 degrees or higher
- Persistent Pressure or Pain in the chest
- Sore Throat
- Runny Nose

I confirm that I do not display or currently have any of the above symptoms that represent the COVID-19 virus:_____(Initial)

I confirm that I have not traveled outside the United States within the past 14 days to any of the countries or regions with widespread ongoing transmission._____(Initial)

Patient Name:_____

Patient/Parent or Guardian Signature:_____

Date: _____

MICHIGAN ORTHODONTICS

COVID-19 Patient Screening Questionnaire

Patient Name:	Relationship to Patient:	**D.O.B:**
New or Existing Patient:	Last Dental Visit:	Telephone:

Dental Emergency Assessment (Circle One):

Are you in Pain?	Yes	**No**
What is your pain level on a scale of 0-10? 10 being the worst pain possible	**0,1,2,3,4,5**	**6,7,8,9,10**
When did the pain begin?	Month:	Date:
Do you have a fever?	Yes	**No**
Are you having any trouble swallowing?	Yes	**No**
Do you have any gum and/or facial swelling?	Yes	**No**
Are you having any trouble opening your mouth?	Yes	**No**
Have you experienced any recent dental trauma to your mouth? If yes, Please describe trauma:	Yes	**No**

Scheduling Requirement Questionnaire/Tasks (Circle One):

In the past 14 days, have you or any household member traveled to any international areas (China, Iran, Italy, Japan, S.Korea, any European country)?	Yes	No
In the past 14 days, have you or any household member had any contact with anyone who had or has had COVID-19?	Yes	No
In the past 14 days have you been exposed to any surfaces or facilities infected with COVID-19?	Yes	No
In the past 14 days, have you or any household members been exposed to any place, personal item, or substance that may have been in contact with someone who is infected by COVID-19?	Yes	No
Have you experienced any of the following in the last 14 days: Fever or respiratory illness such as a cough or difficulty breathing?	Yes	No

Patients Temperature Reading: ••• Doctor will determine if patient is able to receive dental treatment. Comments:	
Patient Services Representative/ Front Desk Employee:	Date:
Clinical Employee:	Date:

Consent for Photography

Enbrite Dental - DBA Michigan Orthodontics

Patient Name:_____ **DOB:**_____

Parent or Legal Guardian: _____

I consent to have my (or child or an individual to whom I provide guardianship) image to be taken by the staff at **Enbrite Dental- DBA Michigan Orthodontics** as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, videotapes, digital, and other images may be recorded to document and assist with my care and the payment of my bill (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of students and residents within the institution. I understand that Enbrite Dental - DBA Michigan Orthodontics will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment, education, and payment purposes, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

If the images are to be taken for any purpose other than for treatment, education, or payment purposes, the purpose(s) must be stated:

_____

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I release and hold harmless **Enbrite Dental- DBA Michigan Orthodontics,** its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____ _____

Patient or Patient Representative Signature Date

_____ _____

If Patient Representative, Relationship to Patient Printed Name