Chenin Orthodontics
Making Smiles, Changing Lives

PATIENT INFORMATION

-Please bring this completed form to your appointment-

Stephen T. Chenin, DDS
David A. Chenin, DDS, MSD

Home Phone _____ Date _____

Work / Cell Phone _____ Email _____

Patient's Name _____ Age (yrs, mo) _____
Last First Middle

Date of Birth ___/___/_____

Preferred Name (Nick Name) _____ ☐ Male ☐ Female SS# _____

Address

How long at address? ____Yrs _____
Street Suite/Apt City State ZIP

If patient is a minor, who is legal guardian _____ Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION

Responsible _____ Marital Status _____
Last First Middle

Residence _____
Street Suite/Apt City State ZIP

Mailing Address _____
(If Different than residence) Street Suite/Apt City State ZIP

How long at this address? _____ Yrs ☐ Rent or ☐ Own

Email _____ Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address _____
(If less than 3 years at current) Street Suite/Apt City State ZIP

Employer _____ Occupation _____ Time at Current Employment _____
Years

Employer Address _____
Street Suite/Apt City State ZIP

Date of Birth Social Security Number Relationship to Patient

Parent Name _____ Relationship to Patient _____
Last First Middle

Date of Birth _____ Social Security Number _____ Work Phone _____

Employer _____ Occupation _____ Years at Current Employment _____

INSURANCE

Dental Insurance Company Name _____ ID # _____ Telephone _____

Dental Insurance Held By _____ SS# _____
(Whose name is on the insurance policy) Last First Middle If not given above

Insured's Employer _____ Insured's Date of Birth: _____

2nd Dental Insurance Company Name _____ ID# _____ Telephone _____

2nd Dental Insurance Held By _____ SS# _____
(Whose name is on the insurance policy) Last First Middle If not given above

Insured's Employer Insured's Date of Birth:

IN CASE OF EMERGENCY Please contact _____ Telephone _____
(nearest relative not living with you) First Last

Complete Address _____
Street Suite/Apt City State ZIP

I pre-authorize the release of patient records/financials to the additional parties listed below to remain in effect until canceled in writing:

_____ ☐Father ☐Mother ☐Relative ☐ Friend

_____ ☐Father ☐Mother ☐Relative ☐ Friend

_____ ☐Father ☐Mother ☐Relative ☐ Friend

_____ ☐Father ☐Mother ☐Relative ☐ Friend

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due to me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office.

.

_____
Signature of Responsible Party

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MEDICAL HISTORY

-Please Answer All Questions-

Patient's Physician _____ Date of Last Visit _____ Patient in good health? ☐ No ☐ Yes

Patient's Height: _____ Patient's Expected Height: _____ Mother's Height _____ Father's Height _____

Has the patient experienced any of the following: For all yes answers please provide specifics below:

Headache Problems	☐ No	☐ Yes	Specifics:	
Sinus/Ear/Nose/Throat Problems	☐ No	☐ Yes	Specifics:	
Eye/Glaucoma/Dizziness Problems	☐ No	☐ Yes	Specifics:	
Muscle/Neural Problems	☐ No	☐ Yes	Specifics:	
Bone / Artificial Joint Problems	☐ No	☐ Yes	Specifics:	
Hormonal Problems	☐ No	☐ Yes	Specifics:	
Blood/Prolonged Bleeding Problems	☐ No	☐ Yes	Specifics:	
Epilepsy/Seizure/Fainting Problems	☐ No	☐ Yes	Specifics:	
Urinary/Liver/Stomach Problems	☐ No	☐ Yes	Specifics:	
Learning/Psychiatric Problems	☐ No	☐ Yes	Specifics:	
Head/Neck/Back Problems	☐ No	☐ Yes	Specifics:	

Allergies ☐ Metal ☐ Latex ☐ Drugs (please list) _____
☐ Plastics ☐ Foods (please list) _____

Please check any that apply: ☐ Dental Anesthetics ☐ Other (Please List):

Childhood Diseases	Heart Problems		Breathing Problems	Chronic Diseases	
☐ Tonsils Removed	☐ Murmur	☐ Poor Blood Pressure	☐ Asthma	☐ Tuberculosis	☐ Cancer
☐ Mumps / Measles	☐ Chest Pain	☐ Heart Valve Problem	☐ Hay Fever	☐ Hepatitis	☐ Radiation
☐ Rheumatic Fever	☐ Angina	☐ Heart Failure/Attack	☐ Wheezing	☐ Diabetes	☐ Chemotherapy
☐ Chicken Pox	☐ Palpations	☐ Coronary Disease	☐ Chronic Cough	☐ HIV/AIDS	

1. Unexpected weight-loss, night sweats, recent travel outside US, bloody sputum, living close quarters or with a tuberculosis patient? ☐ No ☐ Yes
2. List any medications now being taken: _____
3. Patient ever taken Fosamax, Acetenol, Boniva, Aredia, Zometa, bisphosphonates, or any other bone medications? ☐ No ☐ Yes
4. Children: Regarding puberty…If female, has menstruation started? If male, has voice changed? ☐ No ☐ Yes When _____
5. Female Adults Only: Are you currently pregnant? ☐ No ☐ Yes Birth Control? ☐ No ☐ Yes
6. Does the patient smoke, if so how much per day? (write none, or explain): _____
7. Does the patient exhibit any one of the following: Snoring, daytime sleepiness, nightmare/terrors, hyperactivity, mouth breathing? ☐ No ☐ Yes

Any other health problems, surgeries, etc (explain) _____

DENTAL HISTORY

Family Dentist _____ Date of Last Visit _____ Yearly Checkups? ☐ One ☐ Two ☐ Never

Jaw or Face Injury/Trauma	☐ No	☐ Yes	→	☐ Broken Jaw	☐ Other (Explain)	
Tooth Injury/Trauma	☐ No	☐ Yes	→	☐ Broken	☐ Chipped	☐ Lost
Oral Habits (eg pacifier, etc.)	☐ No	☐ Yes	→	☐ Thumb Sucking	☐ Other: _____	Until Age _____
Mouth Problems	☐ No	☐ Yes	→	☐ Mouth Breathing	☐ Tongue Thrust	☐ Grinding/Clenching
Bleeding Gums	☐ No	☐ Yes	→	☐ After Brushing	☐ After Flossing	☐ All times
Ever Had Speech Therapy?	☐ No	☐ Yes	→	Advised By: _____	For: _____	
Jaw Joint Pain	☐ No	☐ Yes	→	Explain: _____		
Jaw Joint Popping/Clicking	☐ No	☐ Yes	→	☐ Both Sides	☐ Right Side	☐ Left Side
Other Dental Problems	☐ No	☐ Yes	→	Explain: _____		

1) Have you been evaluated for orthodontic treatment before? _____ 2) Have you had problems with previous dental work? _____

3) How do you feel about braces? _____

4) What are you most excited about changing in your smile? _____

5) Questions for Dr. Chenin? _____

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing information I have given on this form is correct and that I am obligated to inform Dr. Chenin immediately if any of this information changes in the future.

Patient Name: _____ **Signature** of Patient or Guardian if patient is a minor _____

Doctors Comments: ← OFFICE USE ONLY →

□ All Forms □ Phone
□ Dentist □ Email
□ Spelling □ Signed-in
□ Address □ BlueNote sent to TC

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WELCOME!

Please bring this completed form to your first appointment
….so we can get to know you!

My name is_____

I have family members that come here for orthodontic care & their names are _____

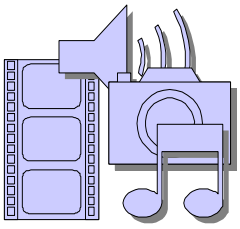
_____

I have a friend(s) that comes here for their orthodontic care and their name is_____

_____ _____

My hobbies are_____

I have a pet_____ and her / his name is_____



My favorite movie or TV show is_____

My favorite song or group is_____

My favorite food is_____

The best thing that ever happened to me was_____

Students Only

I go to school / University of: _____ Grade/Year_____

I love to learn about_____

I wish I could_____

Please let us know how you heard about our office
*(Check **all** that apply and **fill in blanks** below)*

O Dentist_____ Did your Dentist refer you to anyone else?_____

O Friend_____

O Dental staff _____

O Web Search/Site:_____ O Invisalign Website O AAO / ABO Website

O Charity / Sponsorship_____ O School Dental Health Education

O News / Magazine Article_____ O Yellow Pages

O Chenin Change Oral Hygiene Reward Program (Chenin Tokens, t-shirt, waterbottles, etc.)

O Chenin Orthodontics Building or Sign O Other_____

Orthodontics
Dentofacial Orthopedics
Children & Adults

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

10730 South Eastern Avenue, Suite 100
Henderson, Nevada 89052
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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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect April 14, 2003 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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 at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use & disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose you health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for you care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health 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 filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $30 for each record (e.g. photographs, panoramic x-ray, lateral x-ray, etc. are $30 each) which includes time to locate, doctor

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verification, and copy your health information, export, then print or email photos and/or radiographs, and postage if you want the copies mailed to you. If you request, we will prepare a summary or an explanation of your health information for a $95 fee. For a complete download and export of the entire raw DICOM Data File from the 3D X-Ray Image to a CD-ROM Disk, the fee is $195.00 which includes time to locate, doctor verification, processing, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend you 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Retuned Check/Insufficient Funds: For declined payments, a $20.00 declined payment fee is billed to the responsible party. This action may be reported to the Nevada State Check Fraud Commission and further penalties may apply.

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 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 of 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 you 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.

Contact Officer: David Chenin
10730 S. Eastern Avenue, Suite 100
Henderson, NV 89052
Phone: 702-735-1010 Fax: 702-735-6823

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

I have chosen not to sign this acknowledgement. _____ (please initial)

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:

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