Adolescent Registration

# Hudson County Orthodontics L.L.C.

Dr. Michael M. Messana Orthodontist sp. 3901

## 1. Patient Information

First Name: _____

Last Name:_____

Date of Birth: _____/_____/____ Age: _____

Cell #: (_____) _____-_____

Home Address: _____

_____

CITY STATE ZIP

General Dentist: _____

List any main concerns you would like orthodontics to accomplish_____

_____

Whom may we thank for referring you?

_____

## 2. Today's Accompanying Adult

First Name: _____

Last Name:_____

Relation: _____

Cell # (_____) _____-_____

## 3. Mother's Information

☐ Mother ☐ Step Mother ☐ Guardian

First Name: _____

Last Name:_____

☐ Single ☐ Widowed ☐ Separated

☐ Married ☐ Divorced

Date of Birth: _____/_____/_____

Cell #: (_____) _____-_____

Home Address: _____

_____

CITY STATE ZIP

## 4. Father's Information

☐ Father ☐ Step Father ☐ Guardian

First Name: _____

Last Name:_____

☐ Single ☐ Widowed ☐ Separated

☐ Married ☐ Divorced

Date of Birth: _____/_____/_____

Cell #: (_____) _____-_____

Home Address: _____

_____

CITY STATE ZIP

## 5. Primary Orthodontic Insurance

Insurance Co. Name: _____

Policy Holder's Name:_____

Date of Birth: _____/_____/_____

Relation to the Patient: _____

Policy/ ID #:_____

Group #: _____

SSN: _____-_____-_____

Policy Holder's Employer:_____

## 6. Secondary Orthodontic Insurance

Insurance Co. Name: _____

Policy Holder's Name:_____

Date of Birth: _____/_____/_____

Relation to the Patient: _____

Policy/ ID #:_____

Group #: _____

SSN: _____-_____-_____

Policy Holder's Employer:_____

Signature of Parent or Guardian

Date

Adolescent Registration

## 7. Patient Health- Please Check ✓

1. Do you have difficulty, pain, or both when opening your mouth, for instance when yawning? **Yes _____ No _____**

2. Does your jaw get "stuck", "locked", or "go out"? **Yes _____ No _____**

3. Do you have difficulty, pain, or both when chewing, talking, or using your jaws? **Yes _____ No _____**

4. Are you aware of noises from your jaw joints? **Yes _____ No _____**

5. Do your jaws regularly feel stiff, tight or tired? **Yes _____ No _____**

6. Do you have pain in or about the ears, temples or cheeks? **Yes _____ No _____**

7. Do you have frequent headaches and/or neck aches? **Yes _____ No _____**

8. Have you had a recent injury to your head, neck, or jaw? **Yes _____ No _____**

9. Have you been aware of any recent changes in your bite? **Yes _____ No _____**

10. Have you previously been treated for a jaw-joint problem? **Yes _____ No _____**
If so when? _____
_____
_____

11. Have you had any dental x-rays recently? **Yes _____ No _____**

12. Are you allergic to anything? _____
_____
_____

13. Is there any history of heart conditions, rheumatic fever, epilepsy, diabetes, bleeding, aids or mental disorders, other. **Yes _____ No _____**
**If yes, please explain**_____
_____
_____
_____

Signature of Parent or Guardian _____ Date _____

## Authorization for Use of Protection Health Information

To the best of my knowledge, the information on both pages 1 and 2 are complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

I certify that I and/or my dependent(s), have insurance coverage with _____
Insurance company (ies)

and assign directly to Hudson County Orthodontics L.L.C.- under Dr. Michael Messana all insurance benefits, if any, otherwise payable to me for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the used of my signature on all insurance submissions.

The above- named dentist may used my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying, in writing, the office, knowing that previously disclosed information would not be subject to my revoke request.

Signature of Parent or Guardian _____ Date _____

Name of Parent or Guardian (PRINTED) _____

# Authorization and Consent to Send Un-encrypted Patient Information by Email and other Electronic Means

Until I tell you in writing to stop, I authorize Hudson County Orthodontics L.L.C. to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Hudson County Orthodontics' health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Hudson County Orthodontics may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- Hudson County Orthodontics does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Hudson County Orthodontics already sent before receiving my written instructions to stop.

Signature of Parent or Guardian _____ Date _____

Name of Parent or Guardian (PRINTED) _____