Welcome to Krug Orthodontics!!!

New Patient Information for: ______________________________

Preferred Name: ______________________________

Home Phone:		Address:
Work Phone:		
Cell Phone:		Email:
Middle Name	Title	Soc Sec #:
Date of Birth:	Sex:	School:
General Dentist:		Date of Last Dental Visit:

Primary Responsible Party Name: ______________________________

Home Phone:			Address: ☐ Check if same
Work Phone:			
Cell Phone:			Email:
Date of Birth:	Title:	Sex:	Soc Sec #:
Relationship to Patient: ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other:			
Employer:			

Secondary Responsible Party Name: ______________________________

Home Phone:			Address: ☐ Check if same
Work Phone:			
Cell Phone:			Email:
Date of Birth:	Title:	Sex:	Soc Sec #:
Relationship to Patient: ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other:			
Employer:			

Cell phone number to text appointment confirmations to: ______________________________.

Check if you would prefer a voice call to your home telephone for appointment confirmations ☐

Insurance Information

Primary Insurance Company	Secondary Insurance Company
Name:	Name:
Policy holder:	Policy holder:
Phone Number:	Phone Number:
Address:	Address:
Policy #:	Policy #:

PLEASE COMPLETE FULLY AND CONTINUE ON THE NEXT PAGE

Name: ____

Please check any of the medical conditions below that you have had or currently have

☐ AIDS	☐ Diabetes	☐ Hay Fever	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Dizziness	☐ Head Injury	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Epilepsy	☐ Heart Disease	☐ Mental Disorder	☐ Stomach Problems
☐ Artificial Joints	☐ Excessive Bleeding	☐ Heart Murmur	☐ Nervous Disorder	☐ Stroke
☐ Blood Thinner	☐ Fainting	☐ Hepatitis	☐ Pacemaker	☐ Tuberculosis
☐ Blood Disease	☐ Glaucoma	☐ High Blood Pressure	☐ Radiation Treatment	☐ Tumors
☐ Cancer	☐ Growths	☐ Jaundice	☐ Respiratory problems	☐ Ulcers

☐ **Latex Allergy** ☐ **Any other allergies:____________________** ☐ **Any other medical condition: ____________**

- **Do you currently, or have you ever taken bisphosphonate medication (for example Fosamax)? Yes No**
- **Are you currently taking any other medications or vitamins? Yes No**
  If yes, please explain: ____
- **Have you ever had any complications following dental treatment? Yes No**
  If yes, please explain: ____
- **Have you been admitted to a hospital or needed emergency care in the last two years? Yes No**
  If yes, please explain: ____
- **Are you currently under care of a physician? Yes No**
  If yes, please explain: ____
- **Do you have any other health problems? Yes No**
  If yes, please explain: ____
- **Does or did anyone in your family have an underbite (lower teeth in front of upper) Yes No**
  If yes, who: ____

Do you have a thumb or finger sucking habit? ☐ Yes ☐ No
Have you ever been treated with orthodontics before? ☐ Yes ☐ No
Have you ever had trouble associated with previous treatment? ☐ Yes ☐ No
Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No
Have you ever been told that you grind your teeth? ☐ Yes ☐ No
Are you aware that you are clenching your teeth during the day? ☐ Yes ☐ No
Are you aware of jaw clicking or popping? ☐ Yes ☐ No
Do you get frequent headaches, earaches, or have joint pain? ☐ Yes ☐ No
Have you ever experienced ringing in your ears? ☐ Yes ☐ No
Are you a mouth breather? ☐ Yes ☐ No
Are you aware that some of your appointments will be during work/school hours? ☐ Yes ☐ No
If the patient is under the age of 16, what is the patient's height _________ height of Mother __________ Father _______

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my (or my child's) health, I will inform Dr. Krug at my next appointment.

Benefits of Orthodontics: Esthetics, health and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. In addition, I authorize Krug Orthodontics to perform a complete orthodontic evaluation and have the needed orthodontic records (diagnostic photographs, x-rays, and dental impressions) taken. I authorize Krug Orthodontics to file and collect insurance payment for services rendered. I authorize the transmission of my orthodontic records including x-rays, photographs and models in electronic formats including non-encrypted electronic mail.
Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment, activities, and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician, or other healthcare provider consulting with, or providing treatment to you. We may use your photos and records for demonstration or publication purposes. Patient Rights: You have a right to look at or get copies of your health information with limited exceptions. I grant my permission to Krug Orthodontics or its assignee, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content. I have read and understand the above.

____ Date: __________ Relationship to Patient:_____________________
Signature of Patient, Parent, or Guardian

HIPAA Consent Form

Krug Orthodontics
500 River Ave, suite 210
Lakewood, NJ 08701

Patient Name: ___________________________________

HIPAA – Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Krug Orthodontics may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Krug Orthodontics has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice. Our Notice of Privacy Practices is available for you to view by contacting our office. Signing below indicates that you have had the opportunity to review the Notice of Privacy Practices.

I certify that I have had the opportunity to review the Notice of Privacy Practices of Krug Orthodontics.

Name of Responsible Party ____

Relationship to Patient ____

Signature ____ Date ___________________

Permission to Discuss Protected Health Information

Patient Name: ______________________________ Date of Birth: ____________________

Home Address: __________________________ City/State/Zip: _________________________

Home #: ____________________ Work #: ________________________Cell #: ___________________

Many of our patients allow family members such as their parents, grandparents, or others to discuss medical information, medical records, treatment plans and progression. I give permission to Krug Orthodontics (Doctors and staff) to verbally discuss health information, in person, by telephone, or via electronic means (e-mail, texting, fax, etc.) with the following family members or friends involved in my care: (list family members/friends and state the person's relationship to patient). This permission includes scheduling/appointment information, medical and dental health/diagnosis information, treatment plans and treatment progression, insurance coverage, billing/payment information:

Krug Orthodontics has my permission to discuss the above information verbally or in the formats listed above with:

1. Name: ____________________________ Phone: ____________________ Relationship: _______________
2. Name: ____________________________ Phone: ____________________ Relationship: _______________
3. Name: ____________________________ Phone: ____________________ Relationship: _______________
4. Name: ____________________________ Phone: ____________________ Relationship: _______________
5. Name: ____________________________ Phone: ____________________ Relationship: _______________

I understand that I may cancel this permission at any time (cancellation in writing only, to Krug Orthodontics), but that cancelling it will not affect any information that has already been released.

____ Date: _______________ Relationship to Patient: _______________
Signature of Patient, Parent, or Guardian

Authorization and Consent
To Send Unencrypted Patient Information by Email
And Other Electronic Means

Krug Orthodontics
500 River Ave, suite 210
Lakewood, NJ 08701

Patient Name: ___________________________________

Until I tell you in writing to stop, I authorize Krug Orthodontics to transmit patient information relating to my treatment, health, or payment by telephone including the leaving of voice messages, email, text messaging, 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 Krug 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, Krug 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 redisclosed and no longer protected by privacy law.
- Krug Orthodontics does not email or text message 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 or text messages that Krug Orthodontics already sent before receiving my written instructions to stop.

Name of Responsible Party ____

Relationship to Patient ____

Signature ____ Date ___________________