Orthodontic Team
Beyond Your Smile
Sue S. Lee, DMD MMSc

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Email _____ Cell Phone #1 _____ Cell Phone #2 _____

Employer/School _____ Employer/School Phone _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone _____

RESPONSIBLE PARTY

Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone _____

Currently a patient in our office? ☐ Yes ☐ No Email _____ Cell Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit _____

OVER

DENTAL HISTORY

Reason for today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problem with any of the following:

☐ Bad breath
☐ Bleeding gums
☐ Click or popping jaw
☐ Food collection between the teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sleeping / Sleep Apnea
☐ Snoring
☐ Sores or growths in your mouth
☐ Speech

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen phen"? These include combinations of Ionimin, Apidex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approx. dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Check (✓) if you have or had any of the following:

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints, Pins, etc.
☐ Asthma
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ Hernia Repair
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Obstructive Sleep Apnea
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ TMJ Disorder

List medications you are currently taking and the correlating diagnosis: Allergies:

_____ _____

_____ _____

_____ _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the information provided is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance _____ coverage with and assign directly to
Name of Insurance Co(s)

Dr. _____ all insurance benefits, if any otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Co(s) 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.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please print name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

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Beyond Your Smile
254 Cochituate Rd. Framingham, MA 01701
BeyondYourSmile@verizon.net
508-875-1060
Fax: 508-875-0620

Diagnostic Records and Treatment Planning

Patient's Name _____

There is no charge for a New Patient Chair Side Examination.

However, if you have diagnostic records taken and decide not to continue with orthodontic treatment, you will be charged $650.00 for the comprehensive consultation and treatment planning, X-Rays and Photos, less any insurance payment.

Cost Breakdown:

Services	Cost
Diagnostic Records (incl. X-Rays and Photos)	$450.00
Comprehensive Consultation and Treatment Planning with Dr. Lee	$200.00
Total	$650.00

Full payment is appreciated at the diagnostic record and treatment planning appointment. If you have orthodontic insurance, we will submit to your insurance for you. Your insurance coverage may vary as to payment, so you will be responsible for any balance not covered by your insurance.

_____ _____
Signature Date

_____
Print Name

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization for** _____
   Patient's Name

   I authorize Dr Sue S. Lee to use and disclose the protected health information described below to any of my health care providers.
   Signature: _____

2. **Period of Time for Authorization – Please select and sign A or B.**
   a. I authorize Dr. Sue S. Lee to use and disclose the protected health information described below to any of my health care providers for a period of time as follows: from date of _____ to date of _____.
      Signature: _____

   b. I authorize Dr. Sue S. Lee to use and disclose the protected health information described below to any of my health care providers all past, present and future periods.
      Signature: _____

3. **Extent of Authorization – Please select and sign A or B.**
   a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
      Signature: _____

   b. I authorize the release of my complete health record with the exception of the following information:
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol / drug abuse treatment
      ☐ Other (please specify): _____
      Signature: _____

   c. I authorize Dr. Sue S. Lee to share photos of my teeth for the sole purpose of learning and for the sharing of case studies.
      Signature: _____

   d. I authorize Dr. Sue S. Lee to post photos of my teeth and face on her Webpage; BeyondYourSmile.net
      Signature: _____

This authorization shall be in force and effect until _____ at which time this authorization expires. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

I permit email sent between my healthcare providers, myself and/or Dr. Sue S. Lee can be sent over unsecure software.

I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and insurer has a legal right to consent a claim.

I understand that my treatment, payment enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuance to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please print name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient