New Patient (under 18) Registration Form Date: ______

PATIENT

Last Name:_______________________________ First Name: ____________________ Middle Initial____

Birth Date: ________ Age:____ Sex: __Male __Female **Prefers to be called**:____________________

Home Address: ____ Apt#: ___________

City,State,& Zip Code: ______________________________ Home Phone: ________________________

School _______________________Grade_______

For Appointment Reminders:

Cell Phone #:________________________ Email Address:_______________________________________

PARENT/GUARDIAN

Custodial Parent(s) Name(s):____

(check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other ______________

Dentist Name:__________________________________**Office Phone #**___________________________

Father's Name:____ Cell # : _______________________

Mother's Name:____ Cell #:________________________

Dental Insurance: **Please Give Your Insurance Card to Our Receptionist

Name of Dental Insurance Co: _______________________________ID#:___________________________

Policy Holder's Name: __________________________DOB:______SS#:____________________________

Referred by (check) : __Dentist __Insurance __Internet __Friend/Patient (Who:________________)

Allergic to (circle) : Latex Yes/No Nickel (metal) Yes/No

Medical Conditions?____

Signature: ____

INFORMED CONSENT

for the Orthodontic Patient

Risks and Limitations of Orthodontic Treatment

Successful orthodontic treatment is a partnership between the orthodontist and the patient. The doctor and staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that, as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should seriously consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem, and prosthetic solutions or limited orthodontic treatment may be considerations. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

Orthodontics and Dentofacial Orthopedics is the dental specialty that includes the diagnosis, prevention, interception and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

An orthodontist is a dental specialist who has completed at least two additional years of graduate training in orthodontics at an accredited program after graduation from dental school.

American Association of **Orthodontists**

Results of Treatment

Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully.

Length of Treatment

The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structures, if periodontal or other dental problems occur, or if patient cooperation is not adequate. Therefore, changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

Discomfort

The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Non-prescription pain medication can be used during this adjustment period.

Relapse

Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require non-removable retainers or other dental appliances made by your family dentist.

Extractions

Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

Orthognathic Surgery

Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should discuss with your oral and/or maxillofacial surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment!

Decalcification and Dental Caries

Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

Root Resorption

The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

Nerve Damage

A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Orthodontic tooth movement may, in some cases, aggravate this condition. In some cases, root canal treatment may be necessary. In severe cases, the tooth or teeth may be lost.

Periodontal Disease

Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

Injury From Orthodontic Appliances

Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your dentist may be necessary.

Headgears

Orthodontic headgears can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear.

Temporomandibular (Jaw) Joint Dysfunction

Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialists may be necessary.

Impacted, Ankylosed, Unerupted Teeth

Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

Occlusal Adjustment

You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine-tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth, thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Non-Ideal Results

Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

Third Molars

As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

Continued on next page

Patient or Parent/Guardian Initials ___________

Patient ______________________ Date ____________

Allergies

Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

General Health Problems

General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

Use of Tobacco Products

Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic result.

Temporary Anchorage Devices

Your treatment may include the use of a temporary anchorage device(s) (i.e. metal screw or plate attached to the bone.) There are specific risks associated with them.

It is possible that the screw(s) could become loose which would require its/their removal and possibly relocation or replacement with a larger screw. The screw and related material may be accidentally swallowed. If the device cannot be stabilized for an adequate length of time, an alternate treatment plan may be necessary.

It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses.

It is possible that the screws could break (i.e. upon insertion or removal.) If this occurs, the broken piece may be left in your mouth or may be surgically removed. This may require referral to another dental specialist.

When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary.

Local anesthetic may be used when these devices are inserted or removed, which also has risks. Please advise the doctor placing the device if you have had any difficulties with dental anesthetics in the past.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. Fees for these services are not included in the cost for orthodontic treatment.

Patient or Parent/Guardian Initials ________

ACKNOWLEDGEMENT

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment. I also authorize the orthodontist(s) to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

____
Signature of Patient/Parent/Guardian Date

____
Signature of Orthodontist/Group Name Date

____
Witness Date

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(have) no responsibility for any further release by the individual receiving this information.

CONSENT TO USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals.

____
Signature Date

____
Witness Date

I have the legal authority to sign this on behalf of

____
Name of Patient

____
Relationship to Patient

Notes

American Association of **Orthodontists**

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www.AAOmembers.org

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CONFIDENTIAL

Medical Dental History Form for Patients Under Age 18

Patient

Date ____________________

Patient's last name ____________________ First name ____________________ Middle initial ________

Prefers to be called ____________________ Hobbies, activities ____________________

Birth date ____________ Sex ☐ Male ☐ Female Social Security # ____________________

School ____________ Grade ______ Email address(es) ____________________

Home address ____________________ City, State, Zip code ____________________

Home phone ( ) ______-______ Cell phone ( ) ______-______

Parent/Guardian

Custodial parent(s) name(s) ____________________

Patient lives with *(check all that apply)* ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other ____________

Father's full name ____________________ Title: ☐ Mr ☐ Dr ☐ Other ____________

Occupation ____________________ Email address ____________________

Address *(if different)* ____________________

Home phone *(If different)* ( ) ______-______ Cell phone ( ) ______-______ Work phone ( ) ______-______

Mother's full name ____________________ Title: ☐ Mrs ☐ Ms ☐ Dr ☐ Other ____________

Occupation ____________________ Email address ____________________

Address *(if different)* ____________________

Home Phone *(If different)* ( ) ______-______ Cell phone ( ) ______-______ Work phone ( ) ______-______

Dentist

Patient's Dentist ____________________ Address, City, State ____________________

Last seen ____________________ Reason ____________________ Next appointment ________

Other dentists/dental specialists now being seen: Name ____________________ City, State ____________________

Reason ____________________

General Information

What concerns you about your child's teeth? ____________________

What concerns your child about his/her teeth? ____________________

How does your child feel about orthodontic treatment? ____________________

Who suggested that your child might need orthodontic treatment? ____________________

Why did you select our office? ____________________

Describe any previous orthodontic treatment or consultations. ____________________

Does your child play a musical instrument? ____________________

Brother/sister name ______ age ___ had orthodontic treatment? ☐ Yes ☐ No If yes, where? ______
Brother/sister name ______ age ___ had orthodontic treatment? ☐ Yes ☐ No If yes, where? ______
Brother/sister name ______ age ___ had orthodontic treatment? ☐ Yes ☐ No If yes, where? ______
Brother/sister name ______ age ___ had orthodontic treatment? ☐ Yes ☐ No If yes, where? ______
Have any other family members been treated in this office? Please name them. ______

Financial Responsibility

Who is financially responsible for this account? ______
Address *(if different than page 1)* ______ City, State, Zip ______
Home phone ( ) ___-___ Cell phone ( ) ___-___ Email address(es) ______
Social Security # ______ Employer ______
Who will be responsible for bringing the patient to orthodontic appointments? ______

Dental Insurance

Primary policy holder's full name ______ Birth date ______
Social Security # ______ Relationship to patient ______
Address and phone (if not listed above) ______
Employer ______ Address ______
Insurance company ______ Group # ______ ID# ______
Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name ______ Birth date ______
Social Security # ______ Relationship to patient ______
Address and phone (if not listed above) ______
Employer ______ Address ______
Insurance company ______ Group # ______ ID# ______
Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Medical Insurance

Policy holder's full name ______
Insurance Company ______

Physician

Patient's Physician ______ City, State ______
Last seen ______ Reason ______ Next appointment ______
Most recent physical exam ______

Other physicians/health care providers being seen now:
Name ______ City, State ______
Reason ______
Name ______ City, State ______
Reason ______

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

Medical History

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Does your child eat a well-balanced diet?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Does your child frequently breathe through his/her mouth?
- ☐ ☐ ☐ Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ ☐ ☐ Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has your child had allergies or reactions to any of the following?

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances ______________________

Dental History

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Erupting teeth very early or very late?
- ☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Any lost or broken fillings?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ Frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Has your child been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

Patient Health Information

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? ____________________

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication ____________________ Taken for ____________________

Medication ____________________ Taken for ____________________

Medication ____________________ Taken for ____________________

Does your child take antibiotic pre-medication before any dental procedures? ____________________

Does your child have (or ever had) a substance abuse problem? ____________________

Does your child chew or smoke tobacco? ____________________

Have you noticed any unusual changes in your child's face or jaws? ____________________

Any other physical problems? ____________________

Family Medical History

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders ____________________ Diabetes ____________________

Arthritis ____________________ Severe allergies ____________________

Unusual dental problems ____________________ Jaw size imbalance ____________________

Other family medical conditions? ____________________

How often does your child brush? ____________________ Floss? ____________________

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature ____________________ Date ____________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature ____________________ Date ____________________

Medical History Updates or Changes

Changes ____________________

Parent/Guardian Signature ____________________ Date ____________________

Dental Staff Signature ____________________ Date ____________________

Changes ____________________

Parent/Guardian Signature ____________________ Date ____________________

Dental Staff Signature ____________________ Date ____________________

Changes ____________________

Parent/Guardian Signature ____________________ Date ____________________

Dental Staff Signature ____________________ Date ____________________

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WHITE PLAINS
ORTHODONTICS™

Financial Policy Options

In effort to help you in budgeting the financial portion of your orthodontic investment, we have several payment options:

- Option 1 – Interest Free, *Low down* payment and up to 24 months to pay for treatment

- Option 2 – CareCredit or Lending Point with ***zero down*** and extended payment plans with low monthly payments (beyond 24 months will include a finance charge). Insurance is applied to your financial portion.

With CareCredit or Lending Point:

1. Monthly payments to fit almost every budget.
2. There are no annual fees or prepayment penalties.
3. It's a separate line of credit to cover you and your family's healthcare needs, leaving existing credit available for emergencies and other purchases.
4. Take advantage for your down payment or the total treatment fee.

*Insurance is applied to total treatment cost and the remaining patient balance is paid according to option selected above.

NOTE: Please remember that you are ultimately responsible for all charges incurred and that you are responsible for any balance not paid by your insurance company.

We accept Cash, Money Orders, Personal Checks, American Express, Visa, MasterCard and Discover and offer third party financing through CareCredit and Lending Point.

Go to www.carecredit.com

(Lending Point is for Invisalign treatment Financing)

Practice limited to Orthodontics Jeffrey J. Kim, D.D.S. (914) 946-9098
90 Bryant Avenue
1C Embassy Building
White Plains, N.Y. 10605

PATIENT HIPAA AWARENESS

With my permission, Dr. Jeffrey J. Kim, may use, and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Kim's Notice of Privacy Practices for a more complete description of such issues and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Kim reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Kim may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission the office of Dr. Kim may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment card reminders and patient statements as long as they are marked personal and/or confidential.

I have the right to request that Dr. Kim restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Kim to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

____
Signature of Patient or Legal Guardian

_______________________________ ____________________
Patient's Name Date

Print Name of Patient or Legal Guardian____

White Plains Orthodontics, PC
Supplemental Consent/Acknowledgement Form

By signing below and circling “yes”, you consent to allow White Plains Orthodontics, PC to do the following.

- Display your first name and photograph in our office. Yes No
- Display your first name and photograph on our website. Yes No
- Use your orthodontic records for educational purposes. Yes No

Patient’s Name ______________________________________Date________

Signature____