Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask - we will be happy to help.

New Patient Information (CONFIDENTIAL)

Date_____

Name _____ Sex _____ Birth date _____ SS#_____

Address_____ City_____ State____ Zip_____

Home phone_____ Cell phone_____ Work phone_____

Preferred number to send Appointment Text Reminders_____

Email_____

Please Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

Whom May We Thank For Referring You To Us?_____

Emergency Contact_____ Relationship to Patient_____ Phone_____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient_____ Sex_____ Birth date _____ SS#_____

Address_____ City_____ State____ Zip_____

Home phone_____ Cell phone_____

Employer_____ Work Phone_____

Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

Dental Insurance Information

Name of Insured_____

Relationship to Patient_____ Sex_____ **Birth date** _____ **SS#**_____

Name of Employer_____ Union/Local#_____ Work Phone_____

Insurance Company_____ **Group #**_____**Policy ID#**_____

---------IF YOU HAVE ADDITIONAL INSURANCE, PLEASE COMPLETE THE FOLLOWING--------

Name of Insured_____

Relationship to Patient_____ Sex_____ Birth date _____ SS#_____

Name of Employer_____ Union/Local#_____ Work Phone_____

Insurance Company_____ Group #_____Policy ID #_____

Over Please

Patient Medical History

Name of Physician and Location_____ Date of Last Exam_____

		Yes	No
1.	Are you under medical treatment now?.....	☐	☐
2.	Have you ever been hospitalized for any surgeries or illnesses within the last 5 years?..... If yes, please explain_____ _____	☐	☐
3.	Are you taking any medications?..... Including non-prescription medicine? If yes, what medications?_____ _____	☐	☐
4.	Have you ever taken Fen-Phen/Redux?.....	☐	☐
5.	Do you use tobacco?.....	☐	☐
6.	Do you use controlled substances?.....	☐	☐
7.	Do you wear contact lenses?.....	☐	☐
8.	Do you have a persistent cough or throat-clearing not associated with a known illness?	☐	☐

10. Are you allergic to or have any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain) ……	☐	☐
Penicillin or any other Antibiotics.	☐	☐
Sulfa Drugs.....	☐	☐
Barbiturates.....	☐	☐
Sedatives.....	☐	☐
Iodine.....	☐	☐
Aspirin.....	☐	☐
Any Metals (nickel, mercury, etc.)	☐	☐
Latex Rubber.....	☐	☐
Other (please list)_____		

11. Women Only:

		Yes	No
a)	Are you or might you be pregnant?....	☐	☐
b)	Are you nursing?.....	☐	☐
c)	Are you taking contraceptives?.....	☐	☐

9. Do you have or have you had any of the following?

	Yes	No
High Blood Pressure……	☐	☐
Heart Attack…….....	☐	☐
Rheumatic Fever……	☐	☐
Swollen Ankles……	☐	☐
Fainting/Seizures……	☐	☐
Asthma……..…	☐	☐
Low Blood Pressure…….	☐	☐
Epilepsy/ Convulsions….	☐	☐
Leukemia……	☐	☐
Diabetes ……	☐	☐
Kidney Disease……	☐	☐
AIDS or HIV Infection…	☐	☐
Thyroid Problem……	☐	☐

	Yes	No
Heart Disease……	☐	☐
Cardiac Pacemaker……	☐	☐
Heart Murmur……..…	☐	☐
Angina……..…	☐	☐
Frequently Tired……...	☐	☐
Anemia……	☐	☐
Emphysema……	☐	☐
Cancer……	☐	☐
Arthritis……	☐	☐
Joint Replacement or Implant.	☐	☐
Hepatitis/ Jaundice……	☐	☐
Sexually Transmitted Disease..	☐	☐
Stomach Troubles / Ulcers….	☐	☐

	Yes	No
Chest Pains……..	☐	☐
Easily Winded……..	☐	☐
Stroke……	☐	☐
Hay Fever/ Allergies……	☐	☐
Tuberculosis……	☐	☐
Radiation Therapy……	☐	☐
Glaucoma…….....	☐	☐
Recent Weight Loss……	☐	☐
Liver Disease……..….	☐	☐
Heart Trouble……	☐	☐
Respiratory Problems……	☐	☐
Mitral Valve Prolapse……	☐	☐
Other_____		

Patient Dental History

Name of Dentist and Location_____ Date of Last Exam_____

		Yes	No
1.	Are your teeth sensitive to hot or cold liquids/foods?.....	☐	☐
2.	Are your teeth sensitive to sweet or sour liquids/foods?.	☐	☐
3.	Do you feel pain in your teeth?.....	☐	☐
4.	Do you have any sores or lumps in or near your mouth?	☐	☐
5.	Have you had any head, neck, or jaw injuries?.....	☐	☐
6.	Do your gums bleed when brushing or flossing?.....	☐	☐
7.	Have you ever experiences any of the following problems with your jaw?		
	Clicking……	☐	☐
	Pain (joint, ear, side of face)……	☐	☐
	Difficulty opening or closing……	☐	☐
	Difficulty chewing……	☐	☐

		Yes	No
8.	Do you frequently get headaches?.....	☐	☐
9.	Do you clench or grind your teeth?.....	☐	☐
10.	Do you bite your lips or cheeks frequently?.....	☐	☐
11.	Have you ever had any difficult extractions in the past?.....	☐	☐
12.	Have you ever had prolonged bleeding after an extraction?.....	☐	☐
13.	Have you had any orthodontic treatment?.....	☐	☐
14.	Do you wear dentures or partials?..... * if yes, date of placement_____	☐	☐
15.	Have you ever received oral hygiene instruction regarding the care of your teeth and gums?.....	☐	☐
16.	Do you like your smile?.....	☐	☐

Authorization and Release

I certify that I have read and that I understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the orthodontist to release any information including the diagnosis, and the records of any treatment or examination rendered to me during the period of such orthodontic care to third party providers and/or health practitioners. I authorize and request my insurance company to pay directly to the orthodontist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

***X*_____ *Date*_____**

Signature of Patient (or parent/guardian if minor)

Assignment of Benefits and Release of Information

To the practice of

Orthodontic Associates of Lexington
Dr. Yuci Ma
57 Bedford Street, Suite 120, Lexington, MA 02420
781-860-7997

I hereby authorize the Orthodontic Associates of Lexington to release billing information and information requested concerning my care which may include but is not limited to client name, date of birth, date and type of services, diagnoses codes, and/or treatment plans to my insurance company/ies for the purpose of collecting insurance benefits.

I authorize my insurance benefits to be paid directly to the Orthodontic Associates of Lexington or its associated orthodontist. I acknowledge that I am responsible for any balance not covered by those benefits.

_____	_____	_____
Patient or Parent Signature	**Patient Name (please print)**	**Date**

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 legally required by federal and state law to maintain the privacy of your health information and to inform you in writing about our privacy practices and your rights concerning your health information. We must abide by these privacy practices starting 04-14-03, until we replace them when permitted by law, affecting health information we created or received before or after we make any changes. When any changes are made, they will be made available to you upon request.

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 dentist, physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain third party or other payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations including: 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, you may give us written authorization to use your health information or to disclose it to anyone for any purpose, which you may later revoke in writing at any time, not affecting uses or disclosures permitted when your authorization was in effect.
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, with your authorization, disclose your 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.
Persons Involved in Your Care: We may use and disclose your health information to notify a family member, your personal representative, or another person responsible for your care, of your location, your general condition, although you may object to such uses or disclosures if capable. In the event of your incapacity, emergency circumstances, or your death, 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 with you. 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 and disclose your health information when we are required by law to do so.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably 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: Under certain circumstances we may disclose to military authorities the health information of Armed Forces personnel. We may disclose health information required for lawful intelligence, counterintelligence and other national security activities to authorized federal officials. 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 voicemail messages, postcards or letter appointment reminders.

Patient Rights

Access: You have the right to look at or make a written request for copies of your health information, either as photocopies or in some other available format. You may obtain a form from this practice to request access or you may send us a letter to. There will be a minimal fee for photocopying and a reasonable fee for an alternative format.
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 will charge you additional fees for the additional requests. … continued

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, although, we are not required to agree to these additional restrictions. If we do, in writing, we will abide by our agreement, except in an emergency.
A**lternative Communication:** You have the right to request, in writing, that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location that you request.
Amendment: You have the right to request, in writing, that we amend your health information, although we may deny your request under certain circumstances. You must include in your request an explanation of why the information should be amended.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact our office.
If you are concerned that we may have violated your privacy rights in reference to anything stated above, you may submit a written complaint to us and/or 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 privacy and will not retaliate in any way if you choose to file a complaint.

Yuci Ma D.M.D., 57 Bedford Street, Suite 120, Lexington, MA 02420 (781-860-7997)

Acknowledgement of Receipt of "Notice of Privacy Practices

From the Practice of

Dr. Yuci Ma
57 Bedford Street, Suite 120, Lexington, MA 02420
781-860-7997

Patient Acknowledgement

You have the right to refuse to sign this acknowledgement

Please sign this form to acknowledge that you have *today* received a copy of the "Notice of Privacy Practices".

I acknowledge that I have *today* received a copy of the "Notice of Privacy Practices".

_____	_____	_____
Patient or Parent Signature	**Patient Name (please print)**	**Date**

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:

_____ Individual refused to sign

_____ Communications barriers prohibited us from obtaining acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement.

____ Other (please specify_____

_____

Office Personnel Signature:
Office Personnel Name (print):
Date:

SUPPLEMENTAL **INFORMED CONSENT**

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ Yes ☐ No

_____

Patient Name

_____ _____

Parent/Guardian Name *(if applicable)* Relation

_____ _____

Patient/Parent/Guardian Signature Date

CLEAR FORM

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Have you or any family member been diagnosed with COVID-19? Are you or any family member in contact with any confirmed or suspected COVID-19 Patients?	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Patient Visit Protocol and Guidance

What to do before you arrive

- **Please fill out the patient screening form.** The form will be sent to you by email via Docusign 48 hours prior to your scheduled appointment. Please complete the form and send it back within 24 hours. If it is necessary for a parent to escort the child patient for the appointment, the parent will also need to fill out a screening form. If you have symptoms or have recent contact with confirmed/suspected Covid-19 patients, please contact our office. We will assist you to reschedule your appointment.
- **Please read and sign the supplemental informed Consent.** The forms will be sent to you by email via Docusign 48 hours prior to your scheduled appointment. Please read and sign the consent form and send it back within 24 hours.
- **Brush your teeth and rinse with Listerine antibacterial mouthwash before leaving your house.** Our tooth brushing station is currently closed to eliminate the spread of bacteria or viruses.
- **Wear a mask, bandana, or scarf to your appointment.**
- **Do not drink anything cold or hot before you arrive.** We will be checking your temperature with a forehead scanner.

Arrival protocol

- **Please arrive 5 mins before your appointment time. Stay in your car and call our office at 781-860-7997**. Our front desk staff will perform the wellness screening and will receive you at the office entrance. If you are late, we may have to reschedule your appointment due to the restricted patient flow. There will be a charge for missing appointments.
- **Before entering the office we will record your temperature.**
- **We have hand sanitizer that we will ask all patients to use upon entry as well as in the office.**
- **Patients must wear a mask /bandana into the office or will be provided a mask. upon arrival.** Patient's mask should be worn all the time other than during the procedure
- **Social distancing, whenever possible, will be practiced.** This may include limited seating or closure of some part of our waiting room.
- **We ask that only the patient come in for his/her appointment.** If it is necessary for a parent to escort the child patient, the parent will also be subject to the full check-in protocol.

Check out protocol

- Our staff will schedule the next appointment for you, or email /call the parents to update them about their child's procedure and schedule the next appointment.
- In accordance with the CDC and ADA guidelines, please inform us if you develop symptoms, or are diagnosed with COVID-19 within 14 days following the appointment.
- Please make your payment by credit card or check, cash is not accepted.