



Edward Y. Lin, DDS, MS | Lee S. Bialkowski, DDS

Minor Patient Information

1839 Scheuring Road, De Pere, WI 54115 | T 920.336.2299 F 920.347.1872 E osgb@osgb.com
2821 South Webster, Green Bay, WI 54301 | T 920.336.2299 F 920.336.2847 OSGB.COM

All information in this area pertains to the patient

Today's date: _____

Patient name: _____ Age: _____
(Last, First, Middle)

Address: _____ City: _____ State: _____ ZIP: _____

Home phone: _____ Birth date: _____

General dentist: _____

Email: _____

Please describe the concerns that brought you to our office:

Other family members who are patients in our office:

How did you hear about us?
[] General dentist
[] Staff member _____
[] Friend/Family _____
[] Commercial/NEWSureSmile.com
[] Location
[] Internet search
[] Invisalign website
[] Phonebook
[] Other _____

Responsible party is: [] Single [] Married [] Divorced

Insurance benefits are available through:
[] Mother [] Father [] Step-mother [] Step-father [] No insurance benefit

Mother's Information (all info in this area refers to patient's mother)

Name: _____ Home phone: _____
(Last, First, Middle) (complete only if different from patient's information)

Home address: _____ City: _____ State: _____ ZIP: _____
(complete only if different from patient's information)

Employed by: _____ Position: _____

Work phone: _____ SSN: _____ Birth date: _____

Father's Information (all info in this area refers to patient's father)

Name: _____ Home phone: _____
(Last, First, Middle) (complete only if different from patient's information)

Home address: _____ City: _____ State: _____ ZIP: _____
(complete only if different from patient's information)

Employed by: _____ Position: _____

Work phone: _____ SSN: _____ Birth date: _____



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Minor Patient Information continued

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Today's date: _____

Stepmother's Information (all info in this area refers to **patient's stepmother**)

Name: _____ Home phone: _____
(Last, First, Middle) (complete only **if different** from patient's information)

Home address: _____ City: _____ State: _____ ZIP: _____
(complete only **if different** from patient's information)

Employed by: _____ Position: _____

Work phone: _____ SSN: _____ Birth date: _____

Stepfather's Information (all info in this area refers to **patient's stepfather**)

Name: _____ Home phone: _____
(Last, First, Middle) (complete only **if different** from patient's information)

Home address: _____ City: _____ State: _____ ZIP: _____
(complete only **if different** from patient's information)

Employed by: _____ Position: _____

Work phone: _____ SSN: _____ Birth date: _____



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Responsible Party Information

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Patient name: _____ Today's date: _____

Please complete the following for us, in order to set up your account correctly. The account will be set up in this name. It's our goal to make financial arrangements as convenient as possible for all concerned.

Person responsible for paying this account: _____

Home address: _____

City: _____ State: _____ ZIP: _____

I understand that a credit bureau report will be obtained as Orthodontic Specialists of Green Bay offers interest-free payment plans dependent on credit history.

If the person(s) responsible for payment will not be present for the initial appointment, the lower portion of this form must be completed:

In many instances involving divorce, separation or shared custody situations, the individual responsible for payment of an account is different from the person accompanying the patient to the office for care. In these situations, the signature of the person or persons responsible must be provided below.

I (we) the undersigned, accept responsibility for payment of all costs incurred on the behalf of:

Patient name _____

Signature of responsible party _____ Date _____

Signature of responsible party _____ Date _____

If no signature of responsibility is provided, the Laws of Wisconsin state that the person accompanying a minor patient for care is responsible for all financial obligations regardless of court decrees or other legal or personal arrangements.

Initials _____



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Medical & Dental History

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Today's date: Your careful and complete answers to these questions are important. If additional space is needed, please use back of this form.
Patient name: Birth date:
Address: City: State: ZIP:
Home phone: Person completing this form:

General Health Information

Patient's physician:
Patient's dentist:

Is patient currently under a physician's care? If yes, describe medical condition:

Is pre-medication needed for dental appointments?

List all medications/drugs/pills currently being taken:

List any allergies or sensitivities (drug/food/environmental):

Has patient experienced any severe head or facial injuries, including trauma to the teeth? If yes, please describe:

Please check all boxes that apply if you are presently or have been treated in the past for any of the following:

- Heart problems, Heart murmur, Rheumatic fever, Diabetes, Arthritis, High blood pressure, Bleeding disorders, Venereal disease, AIDS, HIV, Previous orthodontic treatment, Benign tumors, Malignant tumors, Kidney problems, Glandular problems, Ulcers, Cancer, Hepatitis, Trauma, Latex allergy, TMJ, Periodontal (gum) disease, Use of tobacco products, Emotional problems, Fainting or dizziness, Epilepsy, Urogenital disease, Convulsions/seizures, Genetic disorders, Tuberculosis, Sleep disorders, Breathing disorders, Asthma, Ear tubes placed, Tonsils removed, Adenoids removed, Glaucoma, Cleft lip or palate, Other (explain on next page)

name of orthodontist:



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Insurance Information

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Patient name: _____
(Last, First, Middle)

The information in this area pertains to a dental insurance company that may help cover the costs of care.

Dental Insurance Does this include orthodontic benefits? Yes No

Insurance company: _____ Phone: _____
Insurance address: _____ City: _____ State: _____ ZIP: _____
Employee: _____ Relationship to patient: _____
Employer: _____ Group #: _____
Insured ID #: _____ SSN: _____

I hereby authorize payment directly to Orthodontic Specialists of Green Bay unless otherwise specified.

Employee's date of birth: _____

Signature of insured person: _____ Date: _____

Dental Insurance 2 Does this include orthodontic benefits? Yes No

Insurance company: _____ Phone: _____
Insurance address: _____ City: _____ State: _____ ZIP: _____
Employee: _____ Relationship to patient: _____
Employer: _____ Group #: _____
Insured ID #: _____ SSN: _____

I hereby authorize payment directly to Orthodontic Specialists of Green Bay unless otherwise specified.

Employee's date of birth: _____

Signature of insured person: _____ Date: _____

Medical Insurance Do not complete this portion if not applicable to your circumstances.*

Insurance company: _____ Phone: _____
Insurance address: _____ City: _____ State: _____ ZIP: _____
Employee: _____ Relationship to patient: _____
Employer: _____ Group #: _____
Insured ID #: _____ SSN: _____

I hereby authorize payment directly to Orthodontic Specialists of Green Bay unless otherwise specified.

Employee's date of birth: _____

Signature of insured person: _____ Date: _____

* In some special instances, medical insurance may cover some orthodontic services. These situations usually involve accidents, birth defects, and sometimes problems involving jaw bones (TMJ). In most cases, medical insurance will not apply.



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Privacy Notice

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This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

PLEASE REVIEW THIS INFORMATION CAREFULLY

Your protected health information (i.e. individually identifiable information, such as names, dates, phone or fax numbers, email addresses, home addresses, social security numbers) may only be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e. American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients & third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment, with your permission;
- We may contact you (via voicemail, e-mail, letters or text messages) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you;
- Other government agencies as required by law.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke. A new privacy notice must be updated at age 18. Should this take place during treatment, please contact us.

Under the privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information in certain circumstances;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information;
- Request an alternate means or location for patient communication. 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 you request; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Officer at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of June 1, 2010. If you have questions regarding the information in the Notice, please contact our Office Administrator, Paula Kaminski, or our Privacy Officer, Laura Ajero, at 336-2299.



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Acknowledgement of Receipt of Notice of Privacy Practices

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Patient name: _____ Date of visit: _____

My signature on this form acknowledges that I've received a copy of Orthodontic Specialists of Green Bay, Ltd.'s Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Orthodontic Specialists of Green Bay, Ltd., and of my rights with respect to my health information.

By signing this form, I consent to Orthodontic Specialists' use of my patient health information to carry out treatment, payment activities, and health care operations as set forth in their Notice of Privacy Practices.

I've been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Patient's signature Date

Signature of patient's representative Date
(use when patient is a minor or unable to sign)

I hereby give consent to Orthodontic Specialists to give my patient information to:

Print name and relationship to patient Date

Print name and relationship to patient Date

Print name and relationship to patient Date

This consent is effective until revoked by me. I may revoke this consent at any time by giving written notice of revocation to Orthodontic Specialists. Revocation of this consent will not affect any action Orthodontic Specialists took in reliance on this authorization before receiving written notice of revocation. Treatment may be declined or discontinued if consent is revoked.

Section below to be completed by Orthodontic Specialists of Green Bay, Ltd. if form is not signed:

1. Was the patient/representative provided with a copy of the Notice of Privacy Practices? YES NO

2. Briefly describe the efforts made to obtain the patient/representative's acknowledgement of receipt of the Notice and explain why the patient/representative was not able or willing to sign this form:

