MYOMY
MYOFUNCTIONAL THERAPY

1150 Glenlivet Drive, Suite C38 Allentown, PA 18106
Phone: 610.395.0980 | Fax: 484.223.1933
www.ghdentistry.com

PATIENT INFORMATION

Patient Name: _____
First Middle Initial Last

Patient Address: _____ City: _____State: _____ Zip: _____

Phone Number: _____Work: _____ Ext: _____ Cell: _____

Email Address if you wish to receive correspondences via email: _____

Birthdate: _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Not Married

Emergency Contact Name: _____ Phone #: _____ Referral Source: _____

Pre-existing Conditions/Diagnosis

- ○ Feeding Disorder
- ○ Seizures
- ○ Chronic Otitis Media
- ○ P-E tube Placement
- ○ Nasal Obstruction
- ○ Enlarged Tonsils / Adenoids
- ○ Asthma
- ○ Pneumonia
- ○ Gastric Reflux
- ○ Snoring
- ○ Sleep study
- ○ C-Pap
- ○ Sleep appliance
- ○ Sinus infections
- ○ Deviated Septum
- ○ Heart Murmur
- ○ Anxiety
- ○ ADD / ADHD
- ○ Depression
- ○ Psychological disorders
- ○ Genetic syndrome
- ○ Sleep apnea
- ○ Difficulty sleeping
- ○ Whip Lash

Medications:
_____
_____
_____
_____
_____

Dental History

Primary/ Baby Teeth
- ○ Late Eruption
- ○ Multiple Cavities
- ○ Injuries
- ○ Extractions

Permanent Teeth
- ○ Late Eruption
- ○ Multiple Cavities
- ○ Injuries
- ○ CM teeth
- ○ Extractions

Orthodontics
- ○ Palatial expansion
- ○ Phase I
- ○ Head gear
- ○ Retainers
- ○ Recurrent ortho

Habits (At any point in life)
- ○ Digit sucking | Duration:_____
- ○ Pacifier | Duration:_____
- ○ Sippy Cups | Duration:_ _____
- ○ Nail Biting | Duration:_____
- ○ Tongue Sucking | Duration:_____
- ○ Object Chewing | Duration:_____

Notes:_____

Developmental History

Pregnancy:
- ○ Normal
- ○ Abnormal
- ○ Early
- ○ Term
- ○ Late

Feeding History:
- ○ Breast
- ○ Bottle
- ○ Combo
  Until age___

Milestones:
- ○ Early
- ○ On track
- ○ Late

Feeding Therapy:
- ○ Yes
- ○ No

Speech Therapy:
- ○ Yes
- ○ No

Allergies:
- ○ None Known
- ○ Seasonal
- ○ Environmental
- ○ Food
- ○ Allergic shiners

Eating:
- ○ Requires a lot of fluid during mealtime
- ○ Can swallow pills
- ○ Cannot swallow pills

Notes:_____

Sleep History

- ○ Mouth breathing-Night
- ○ Snoring
- ○ Breath loud/ heavy
- ○ Trouble breathing
- ○ Witnessed your child stop breathing
- ○ Nightly bathroom trips
- ○ Mouth Breathing- Day
- ○ Bed wetting
- ○ Awake in the morning not refreshed.
- ○ Day time sleepiness
- ○ Difficult to wake in the
- ○ Awake in the morning with headaches
- ○ Decrease in growth
- ○ Tossing and turning
- ○ Awkward sleep positions
- ○ Night terrors
- ○ Easily distracted by extraneous stimuli
- ○ fidgets with hands and feet or squirms in seat
- ○ interrupts or intrudes on others
- ○ Tends to be always "On the Go"

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MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes _____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes _____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes _____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes _____
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? ☐ If yes _____

Do you use controlled substances? ◯ Yes ◯ No If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X_____ DATE _____

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FINANCIAL POLICY

Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as manageable for our patients as possible.

Insurance

Payment is due at the time of service. If you have dental insurance, we will be glad to submit an electronic claim to your carrier on your behalf, so that you can be reimbursed quickly and efficiently. While our dental team is happy to help you with your coverage, it is important that you are familiar with your plan. All policies differ in payment schedule, deductibles, annual maximums, allowable fees, etc.

Payment Options

We accept:

- Cash
- Check
- Visa, Mastercard, American Express, and Discover credit cards

For your convenience, if the person responsible for the patient's account payments will not be present at the time of their appointments, we will be happy to keep a current credit card number on file.

If you prefer to pay for your treatment in installments, please ask about our interest-free financing programs. Our flexible payment options assure that you can afford to have the care you want.

Convenient Monthly Payment Options:

- CareCredit Healthcare Credit Card
- DentalBank
- For treatment over $2000, payments can be made in thirds.
- For treatment requiring 4 appointments or more to complete, alternative payment arrangements may be provided

Please Note:

Any account balance over 90 days old will be considered "past-due" and will be charged at an interest rate of .015% (18% annually) per month.

If your account needs to be referred to collections, you will be responsible for the cost of collection, as well as any court costs and reasonable attorney's fees.

I have read and accept the Financial Policies of Green Hills Family & Cosmetic Dentistry as outlined above.

Patient Name_____ Signature: _____ Date: ____ / ____ /_____
(Please Print) (Patient, Parent or Guardian)

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APPOINTMENT POLICY

At MyoMy, we understand circumstances can change, therefore, we request that patients notify us at least 24 hours in advance if they need to cancel or reschedule an appointment.

This allows us to manage our schedule effectively and offer the time slot to another patient in need.

Cancellations or rescheduling requests with less than 24 hours notice may result in a cancellation fee of $40.00 charged to your account.

We appreciate your understanding and cooperation in ensuring we can provide timely and efficient care to all of our patients. Please note we consider exceptions for unavoidable emergencies on a case-by-case basis.

In our Mini Myo programs, such as **Habit Elimination** and **Tethered Oral Tissue Preparation**, there is a specific set of appointments to achieve individualized goals. The cost of the program, as explained in your treatment plan, includes all the appointments needed for success.

If additional appointments are needed beyond the allotted amount for the program a re-evaluation will help to determine if further treatment is needed.

I have read and accept the policies and procedures of MyoMy @ Green Hills Dentistry as outlined above.

Patient Name_____Signature:_____Date:___/___/___
(Please Print) (Patient, Parent, or Guardian)

Photo Release

Please Initial:_____ I hereby grant permission to MyoMy Myofunctional Therapy to take photographs and video for the purpose of evaluating the presence of orofacial myofunctional disorders.

Please Initial:_____ Myofunctional therapy often requires a collaborative approach to care. MyoMy may send reports that include photos from treatment to other members of your treatment team i.e. orthodontist, ENT, chiropractor.

I herby grant permission to MyoMy Myofunctional Therapy to use photos and/or video for the purpose of collaborating treatment.

Print Name: _____ **Signature:** _____

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POLICIES AND PROCEDURES

Welcome to Green Hills Family & Cosmetic Dentistry! Our mission is to deliver world class dental care with a keen focus on patient service. We respect your trust in our ability to help you protect your dental health, and improve your smile. We are confident that you will feel comfortable with our caring professional staff, and state of the art facility. What follows is a brief summary of our practice policies and procedures. If you have any questions or need further clarification, we will be happy to accommodate you.

Thank you again for letting us earn your trust. We work hard to exceed your expectations.

_____ Initials

Appointments

We see patients by appointment only, and are pleased to offer extended office hours. If you must change an appointment, please notify us more than **24 hours** in advance. This will allow us to offer that reserved time to another patient who needs treatment.

A fee of $50 is charged to patients who miss or cancel more than 2 appointments in a calendar year without 24-hour notice. Patients who have two or more broken appointments, at the discretion of the office, may be required to provide a deposit before an appointment can be scheduled.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____ Initials

Emergency Care

If you should have an emergency, please call the office as early in the day as possible so we may see you promptly. If the office is closed, we can be reached via the phone number left on our voice mail system.

_____ Initials

Patient Confidentiality

Our office follows the Federal "HIPAA" Health Insurance Portability and Accountability Act. We **do not** sell your personal or medical information to anyone. We **do not** share your information with anyone other than your insurance carrier, pharmacist, or other medical or dental specialists. We keep all your information confidential. Please read a copy of our policy.

I acknowledge that I have read a copy of Green Hills Family and Cosmetic Dentistry **NOTICE OF PRIVACY PRACTICES.**

Please let us know how you would like to be contacted (check all that apply)*:
*Our patients like our email and text appointment reminders!

- ☐ **Home Phone Number:** _____
- ☐ **Cell Phone Number:** _____
- ☐ **Email:** _____
- ☐ **Text:** _____

I have read and accept the Policies and Procedures of Green Hills Family & Cosmetic Dentistry as outlined above.

Patient Name_____ Signature: _____ Date: ____ / ____ /_____
(Please Print) (Patient, Parent or Guardian)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

~ When a state or federal law mandates that certain health information be reported for a specific purpose;
~ For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
~ Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
~ Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
~ Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
~ Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
~ Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
~ Uses or disclosures for health related research;
~ Uses and disclosures to prevent a serious threat to health or safety;
~ Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
~ Disclosures of de-identified information;
~ Disclosures relating to worker's compensation programs;
~ Disclosures of a "limited data set" for research, public health, or health care operations;
~ Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
~ Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

(OVER)

(CONTINUED FROM FRONT)

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

~ Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

~ Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Green Hills Family & Cosmetic Dentistry, P.C. Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____