FAMILY ORTHODONTICS of Dublin

Patient Information *Child*

First Name:_____ Last Name:_____ Nickname:_____ Sex: ☐ M ☐ F

Birthdate:_____ Age:_____ School:_____ Grade:_____

Address:_____City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

What is your preferred choice for appointment confirmations? ☐ Home Phone ☐ Cell Phone ☐ Email

Hobbies/Interests:_____

Name and Ages of Siblings:_____

Please list any family member that has been a patient in our office:_____

Patient lives with:_____ Relationship to the patient:_____

Whom may we thank for referring you to our office?_____

Dentist Name:_____ Phone:_____ City:_____

Person Responsible for this Account

Name:_____ Relationship to the patient:_____

Address:_____City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Remarried

Mother's Name:_____ Social Security #_____-_____-_____ Driver's Lic #_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Occupation:_____

Father's Name:_____ Social Security #_____-_____-_____ Driver's Lic #_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Occupation:_____

Dental Insurance

Mother's Dental Insurance:_____ Group #_____

Subscriber's ID:_____ Mother's Birthdate:_____

Insurance Phone: _____

Father's Dental Insurance:_____ Group #_____

Subscriber's ID:_____ Father's Birthdate:_____

Insurance Phone: _____

(Continued on back)

FAMILY ORTHODONTICS of Dublin

Medical and Dental History

Does your child currently have or have they ever had any of the following (*please check yes or no*):

Arthritis	Yes	No	Epilepsy	Yes	No	Metal Allergy	Yes	No
Asthma	Yes	No	Headaches	Yes	No	Mouth Breathing	Yes	No
Back or Neck problems	Yes	No	Head/brain injury	Yes	No	Nervous disorders	Yes	No
Bleeding disorder	Yes	No	Heart murmur	Yes	No	Periodontal (Gum) Problems	Yes	No
Bone disorder	Yes	No	Heart problems	Yes	No	Rheumatic Fever	Yes	No
Bulimia	Yes	No	Hepatitis	Yes	No	Thyroid problems	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No	Tooth Grinding	Yes	No
Chest Pains	Yes	No	Jaw or Jaw joint Pain	Yes	No	Trauma to face/teeth	Yes	No
Diabetes	Yes	No	Latex Allergy	Yes	No	Tuberculosis (TB)	Yes	No

Does your child have any disease, problem, or illness not mentioned above? ☐ No ☐ Yes, please specify: _____

_____

Does your child currently take any medications? ☐ No ☐ Yes, please list: _____

_____

Does your child have any allergies? ☐ No ☐ Yes, please specify: _____

_____

Physician: _____ Phone:_____ City:_____

Last date seen by physician: _____

Female Patients: Has your child begun menstruation? ☐ No ☐ Yes If so, at what age did menstruation begin? _____

Has your child ever sucked a thumb or finger? If so, to what age? _____	Yes	No
Any speech problems?	Yes	No
Any breathing problems?	Yes	No
Any pain or noises while opening or closing the mouth?	Yes	No
Are you aware of any missing or extra teeth?	Yes	No
Are you aware of any tongue-thrust problems?	Yes	No
Have you consulted with another orthodontist about your child's problem?	Yes	No
Has your child had previous orthodontic treatment?	Yes	No
For the patient: Are you happy with the way your teeth look now?	Yes	No
For the patient: Are you willing to wear metal braces, elastics, retainers, etc. to help straighten your teeth?	Yes	No

What are your reasons for choosing to seek orthodontic treatment? _____

_____

I, _____ authorize this facility to examine and provide orthodontic treatment. I accept full responsibility for any balance due. I authorize my insurance company to make payments directly to this facility when applicable. I understand it is my responsibility to know all the rules and restrictions of my insurance policy including orthodontics. I authorize this facility to release any dental or incidental information that may be necessary for either dental care or in processing application for financial benefit. I understand that this office reserves the right to verify the credit status of potential patients or responsible party/guardian of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Patient or Responsible Party:

Signature_____**Date**_____

(Rev.010411)

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 required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 1, 2009 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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 physician or other healthcare provider providing treatment to you. The doctor and staff may discuss patient's treatment with other doctors and staff. We may request x-rays and patient information from other dentist's office. We may use fax and e-mail for required information regarding patients, patient's treatment, health history, insurance, etc. Aligner patients require us to enter treatment information over the internet.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mails, postcards, or letters).

In-Office Policy: We may place patient names and pictures on monitors, boards and signs in and around the office. Patient's names and some personal information is printed and posted on a daily schedule. The doctors and staff communicate, (talk in the office while others are present), with patients and parents regarding treatment, etc.

Payment: We may use and disclose your health information to process insurance eligibility and benefits as well as to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include 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 to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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 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, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, 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 in your healthcare. 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 or disclose your health information when we are required to do so by law.

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: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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 February 1, 2009. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint 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 the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Updated: February 22, 2009

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
&
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AGREEMENT

Purpose: By signing this Agreement, you acknowledge that you have received a copy of our Notice of Privacy Practices and that you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Agreement. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Agreement. We encourage you to read it carefully and completely before signing this Agreement. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ (*patient name*), have had full opportunity to read and consider the contents of this Agreement. I understand that, by signing this Agreement, I have received a copy of the Notice of Privacy Practices and am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Updated: February 22, 2009