PATIENT INFORMATION

Highlighted Portions are REQUIRED

DATE_____

PATIENT'S NAME_____
LAST *FIRST* *M.I.*

ADDRESS_____
STREET *CITY* *ZIP*

NICKNAME_____ BIRTHDATE_____ GENDER_____ SOCIAL SECURITY #_____

SCHOOL_____ SPORTS/HOBBIES_____

EMPLOYER_____OCCUPATION_____ # OF YEARS EMLOYED_____

HOME #_____CELL #_____

WORK/OTHER #_____ EMAIL ADDRESS_____

FOR FUTURE APPOINTMENTS, HOW WOULD YOU LIKE TO BE REMINDED? _____TEXT _____EMAIL

PARENT OR GUARDIAN NAME_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

Please list any other children in the household below: *Name / Gender / DOB*

_____

_____

_____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

NAME_____
LAST *FIRST* *M.I.*

RESIDENCE_____
STREET *CITY* *ZIP*

HOME #_____CELL #_____

WORK/OTHER #_____ EMAIL ADDRESS_____

SOCIAL SECURITY #_____ BIRTHDATE_____RELATIONSHIP TO PATIENT_____

EMPLOYER_____OCCUPATION_____ # OF YEARS EMPLOYED_____

SPOUSE'S NAME_____ RELATIONSHIP TO PATIENT_____

EMPLOYER_____OCCUPATION_____ # OF YEARS EMPLOYED_____

SOCIAL SECURITY #_____BIRTHDATE_____WORK #_____

FOR FUTURE APPOINTMENTS, HOW WOULD YOU LIKE TO BE REMINDED? _____TEXT _____EMAIL

DENTAL INSURANCE INFORMATION (If Applicable)

INSURED'S NAME_____INSURED SOCIAL SECURITY #_____

INSURANCE COMPANY_____GROUP #_____LOCAL (ID) #_____

INSURANCE CO. ADDRESS_____PHONE #_____

DO YOU HAVE DUAL COVERAGE?_____ IF YES:

INSURED'S NAME_____INSURED SOCIAL SECURITY #_____

INSURANCE COMPANY_____GROUP #_____LOCAL #_____

INSURANCE CO. ADDRESS_____PHONE #_____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU_____

ADDRESS_____
STREET *CITY* *ZIP*

HOME #_____CELL #_____ALTERNATE #_____

I UNDERSTAND THAT, WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

PATIENT/RESPONSIBLE PARTY SIGNATURE_____

More information on next page →

MEDICAL HISTORY

PHYSICIAN_____DATE OF LAST VISIT_____
ADDRESS_____PHONE_____
PLEASE CIRCLE YES OR NO (IF YES, PLEASE FILL IN DETAILS):

YES NO IS THE PATIENT TAKING ANY MEDICATION?_____
YES NO IS THE PATIENT ALLERGIC TO ANY MEDICATION?_____
YES NO HISTORY OF A MAJOR ILLNESS?_____
YES NO HAS THE PATIENT HAD ANY OPERATIONS?_____
YES NO EVER BEEN INVOLVED IN A SERIOUS ACCIDENT?_____
YES NO HAVE SEEN A PHYSICIAN IN THE LAST 12 MONTHS? WHY?_____

FEMALE PATIENTS ONLY:

YES NO HAS MENSTRUATION STARTED?_____
YES NO IS THE PATIENT PREGNANT?_____

CIRCLE ANY OF THE MEDICAL CONDITIONS BELOW THAT THE PATIENT HAS HAD OR CURRENTLY HAS:

ABNORMAL BLEEDING/HEMOPHILIA	DIABETES	HEPATITIS/LIVER PROBLEMS	PNEUMONIA
ANEMIA	DIZZINESS	HERPES	PROLONGED BLEEDING
ARTHRITIS	EPILEPSY	HIGH BLOOD PRESSURE	RADIATION/CHEMOTHERAPY
ASTHMA OR HAYFEVER	GASTROINTESTINAL DISORDERS	HIV/AIDS	RHEUMATIC FEVER
BONE DISORDERS	HEART PROBLEMS	KIDNEY PROBLEMS	TUBERCULOSIS
CONGENITAL HEART DEFECT	HEART MURMUR	NERVOUS DISORDERS	TUMOR OR CANCER

ARE THERE ANY MEDICAL CONDITIONS WE HAVE NOT DISCUSSED THAT YOU FEEL WE SHOULD BE AWARE OF?_____
_____

DENTAL HISTORY

GENERAL DENTIST_____DATE OF LAST VISIT_____
WHAT CONCERNS YOU MOST ABOUT YOUR TEETH?_____

YES NO IS THE PATIENT PRESENTLY IN ANY DENTAL PAIN?_____
YES NO EVER EXPERIENCED ANY UNFAVORABLE REACTION TO DENTISTRY?_____
YES NO HAS THE PATIENT EVER LOST OR CHIPPED ANY TEETH?_____
YES NO HAVE THER BEEN ANY INJURIES TO FACE, MOUTH OR TEETH?_____
YES NO IS ANY PART OF YOUR MOUTH SENSITIVE TO TEMPERATURE? WHERE?_____
YES NO IS ANY PART OF YOUR MOUTH SENSITIVE TO PRESSURE? WHERE?_____
YES NO DO GUMS BLEED WHEN BRUSHING?_____
YES NO ANY TYPE OF THUMB OR TONGUE HABIT?_____
YES NO IS THE PATIENT A MOUTH BREATHER?_____
YES NO HAS THE PATIENT EVER SEEN AN ORTHODONTIST? WHO? WHEN?_____
YES NO WHAT IS THE PATIENT'S ATTITUDETOWARD RECEIVING ORTHODONTIC TREATMENT?_____
YES NO HAS ANYONE IN THE FAMILY RECEIVED ORTHODONTIC TREATMENT? HOW DID THEY FEEL OF THEIR RESULT?_____
_____
YES NO DO TEETH OR JAWS EVER FEEL UNCOMFORTABLE FIRST THING IN THE MORNING?_____
YES NO EXPERIENCE JAW CLICKING OR POPPING?_____
YES NO AWARE OF CLENCHING OR GRINDING TEETH DURING THE DAY?_____
YES NO EXPERIENCE "TENSION" HEADACHES?_____
YES NO HAS THE PATIENT EVER EXPERIENCE CHRONIC RINGING IN THE EARS?_____
YES NO DOES THE PATIENT NEED EXTRA HELP WITH INSTRUCTIONS?_____
YES NO IS THE PATIENT SENSITIVE OR SELF-CONCIOUS ABOUT HIS/HER TEETH?_____
YES NO HEIGHT OF PARENTS? MOM_____DAD_____
YES NO ARE YOU AWARE THAT SOME APPOINTMENTS WILL BE DURING SCHOOL HOURS?_____

BENEFITS:

BENEFITS OF ORTHODONTICS: AESTHETICS, HEALTH & FUNCTION. ORTHODONTICS IS A SERVICE THAT PROVIDES AN IMPROVEMENT IN THE APPEARANCE OF THE TEETH, IN THE GENERAL FUNCTION OF THE TEETH, AND IN GENERAL DENTAL HEALTH. TEETH, GUMS, AND JAWS ARE AN INTRICATE BODY PART AND CAN FAIL TO RESPOND TO TREATMENT. IF GOOD ORAL HYGIENE IS NOT PRACTICED, TOOTH DECAY AND ENLARGED GUMS CAN RESULT. JOINT DISCOMFORT AND ROOT SHORTENTING ARE OBSERVED IN A SMALL PERCENTAGE OF CASES. TEETH CHANGE THROUGHOUT OUR LIFETIME AND THERE CAN BE SOME MOVEMENT OF TEETH AND SOME CHANGE AFTER TREATMENT. I HAVE READ AND UNDERSTAND THIS PARAGRAPH. I ALSO UNDERSTAND THAT MY DIAGNOSTIC RECORDS AND MY NAME MAY BE USED FOR EDUCATIONAL AND PROMOTIONAL PURPOSES. I HAVE TRUTHFULLY ANSWERED ALL OF THE ABOVE QUESTIONSAND AGREE TO INFROM THIS OFFICE OF ANY CHANGES IN MY MEDICAL OR DENTAL HISTORY. IN ADDITION, I AUTHORIZE DR. CHUDASAMA TO PERFORM A COMPLETE ORTHODONTIC EVALUATION.

_____ _____

PATIENT/RESPONSIBLE PARTY'S SIGNATURE **DATE**

More information on next page →

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health – related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to receive an accounting of disclosures of protected health information.

More information on next page →

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against your for filing a complaint.

_____
Date

_____
Patient/Responsible Party Signature

_____
Print Patient Name

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

202-619-0257
1-877-696-67750 (Toll Free)