

Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can and **bring it to the Exam Visit**. If you have questions we'll be glad to help you. We look forward to working with your child.

Child's Name _____ Soc. Sec. # _____

(Last) (First) (Initial)
Address _____

City _____ State _____ Zip _____ Phone _____ Sex: M F Age _____

Birthdate _____ School _____ Grade _____ Hobbies/Sports _____

Mother's Name/Address _____

Father's Name/Address _____

Other family members who are patients here? _____

Whom may we thank for referring you? _____ Dentist _____

Person Responsible for Account _____

(Last) (First) (Initial) (Birthdate)
Relation to Child _____ Soc. Sec. # _____ Home Phone _____

Cell Phone _____ Email _____

Employer of Resp. Party _____ Occupation _____ Business Phone _____

To whom do you want correspondence sent? _____

Primary Orthodontic Insurance

Insurance Company _____ Phone _____ Group # _____
Subscriber Name _____ Relation to Child _____ Birthdate _____ Soc. Sec. # _____
Address (if different from child) _____ City _____ State _____ Zip _____
Phone _____ Subscriber Employed by _____ Business Phone _____

Additional Orthodontic Insurance

Insurance Company _____ Phone _____ Group # _____
Subscriber Name _____ Relation to Child _____ Birthdate _____ Soc. Sec. # _____
Address (if different from child) _____ City _____ State _____ Zip _____
Phone _____ Subscriber Employed by _____ Business Phone _____

Dental History

Why are you interested in orthodontic treatment for your child? _____

Date of last dental care _____

How often does your child brush? _____ Floss _____

Has your child ever had orthodontic treatment? Yes ___ No ___

Has your child ever experienced a mouth or chin injury? Yes ___ No ___

Does your child have any habits/problems affecting the mouth or teeth? (suck thumb/fingers?) _____

Which musical instruments does your child play? _____

Does your child usually breathe through his/her mouth while awake? Yes ___ No ___ Or asleep Yes ___ No ___

Has your child ever had a problem during or in conjunction with a medical or dental procedure? _____

Other information about your child's dental health or previous treatment. _____

Please complete both sides

Medical History

Child's Physician _____ Phone _____ Date of last visit _____

Has your child had any serious illnesses or operations? Yes ___ No ___

If yes, describe _____

Taking any medications? _____ List _____

Any allergies to medications? _____

Is your child currently under physician care? Yes ___ No ___ If yes, describe _____

Have the child's adenoids or tonsils been removed? Yes ___ No ___

Check (✓) if your child has had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Allergy Prone | Need premed? ___ | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hemophilia/
abnormal bleeding | <input type="checkbox"/> Thyroid disease/
malfunction |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease or
malfunction | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Convulsions/ epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Material allergies
(latex , wool, metal,
chemicals) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Respiratory disease | |
| <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Emotional disorder | | |
| <input type="checkbox"/> Fainting | | |

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1. By signing this form, the undersigned acknowledges that they have legal responsibility for above listed patient.
 2. The undersigned hereby authorizes the doctor to do an exam and request any necessary x-rays, study models, photographs or diagnostic aids deemed appropriate.
 3. I also authorize the doctor to perform all recommended treatment mutually agreed upon by both and consent that the doctor choose and employ such assistance as deemed fit to provide quality care.
 4. I consent to allowing my child's diagnostic records to be used for professional, educational presentations.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate orthodontic treatment. If there is any change in my child's medical status, I will inform the orthodontist.

I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been made.

Elizabeth A. Long, D.D.S.

Practice Limited to Orthodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

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
 - Communication barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (please specify)
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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 April 14, 2003, 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.

Payment: We may use and disclose your health information 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.

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

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 \$0.10 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 April 14, 2003. 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.

Contact Officer: Elizabeth A. Long, D.D.S.

Telephone: 512-892-5511

Fax: 512-892-2061

E-mail: _____

Address: 3421 W. William Cannon, Suite 143

Austin, Texas 78745

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