

(Child Patient)

Welcome

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.
Thank You!



Patient Information

Patient Name _____
(First) (Middle) (Last)
 Male Female Social Security Number _____ Birth Date _____ Age _____
Home Address _____ City _____ State _____ Zip _____
Primary Phone Number _____ Home Cell Ok to Leave Message? Yes No
E-mail _____ School _____ Grade _____
List Any Sports or Extracurricular Activities _____
Siblings (Names and Ages) _____
Have any had Orthodontic treatment? Yes No

Parent / Guardian Information

Marital Status Single Married Divorced Widowed Significant Other
 Mother Step-Mother Guardian Other
Name _____ Birth Date _____
(First) (Middle) (Last)
Address (If Different than Child's) _____ City _____ State _____ Zip _____
Phone Number _____ Home Cell Secondary Phone Number _____ Home Cell
Employer's Name _____ Occupation _____ Phone Number _____
 Father Step-Father Guardian Other
Name _____ Birth Date _____
(First) (Middle) (Last)
Address (If Different than Child's) _____ City _____ State _____ Zip _____
Phone Number _____ Home Cell Secondary Phone Number _____ Home Cell
Employer's Name _____ Occupation _____ Phone Number _____

Emergency Contact Information

Emergency Contact Name (Other than Parent) _____
Phone Number _____ Relation to Child _____
Address _____ City _____ State _____ Zip _____

Insurance Information

Primary Insurance Company _____ Phone Number _____
Group Number _____ Policy Number _____ Member ID Number _____
Policy Holder's Name _____ Relation _____
Policy Holder's SSN _____ Policy Holder's Date of Birth _____
Employer _____ Work Phone Number _____

Secondary Insurance Company _____ Phone Number _____
Group Number _____ Policy Number _____ Member ID Number _____
Policy Holder's Name _____ Relation _____
Policy Holder's SSN _____ Policy Holder's Date of Birth _____
Employer _____ Work Phone Number _____

Dental History

General Dentist _____ Last Visit _____

How did you hear about our practice? Ad Internet Family/Friend Physician Dentist Other

Name of Person Referring (If Applicable) _____

What are the main concerns you would like Orthodontics to accomplish?

Concerns _____

Has your child had an Orthodontic consultation before? Yes No

Has your child had Orthodontic treatment before? Yes No

If so, explain _____

Have we treated any other family members? Yes No

Have your child's Tonsils or Adenoids been removed? Yes No

Has your child ever experienced jaw joint pain / discomfort (TMJ/TMD)? Yes No

Does your child have any missing or extra permanent teeth? Yes No

Has your child ever had an injury to (select all that apply)? Teeth Mouth Chin

Does your child currently or has your child ever had any of the following habits (check all that apply)?

- | | | |
|--|--|--|
| <input type="radio"/> Clenching / Grinding Teeth | <input type="radio"/> Lip Sucking / Biting | <input type="radio"/> Mouth Breathing |
| <input type="radio"/> Nail Biting | <input type="radio"/> Thumb / Finger Sucking | <input type="radio"/> Chewing / Eating Problem |

Medical History

Is your child currently being treated by a physician Yes No

Reason _____ Physician _____

Last Visit _____ Phone _____

Does your child have any allergies / sensitivities to medications? Yes No

If yes, please list _____

Does your child have any allergies / sensitivities to Latex? Yes No

Has puberty and/or menstruation begun? Yes No

Has your child had any serious illnesses or operations? If yes, describe:

Check if your child has ever had any of the following:

- | | | | |
|---|--|---|--|
| <input type="radio"/> ADD/ADHD | <input type="radio"/> Circulatory Problems | <input type="radio"/> Hemophilia | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Anemia | <input type="radio"/> Cortisone Treatments | <input type="radio"/> Hepatitis | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Arthritis, Rheumatism | <input type="radio"/> Cough, Persistent | <input type="radio"/> High Blood Pressure | <input type="radio"/> Skin Rash |
| <input type="radio"/> Artificial Heart Valves | <input type="radio"/> Coughing Blood | <input type="radio"/> HIV/AIDS | <input type="radio"/> Stroke |
| <input type="radio"/> Artificial Joints | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease | <input type="radio"/> Swelling of Feet or Ankles |
| <input type="radio"/> Asthma | <input type="radio"/> Epilepsy | <input type="radio"/> Liver Disease | <input type="radio"/> Thyroid Problems |
| <input type="radio"/> Back Problems | <input type="radio"/> Fainting | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Blood Disease | <input type="radio"/> Glaucoma | <input type="radio"/> Pacemaker | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Cancer | <input type="radio"/> Headaches | <input type="radio"/> Radiation Treatment | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Chemical Dependency | <input type="radio"/> Heart Murmur | <input type="radio"/> Respiratory Disease | <input type="radio"/> Ulcer |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Heart Problems | <input type="radio"/> Rheumatic Fever | |

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status.

I hereby authorize the release of any information pertaining to my child's medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payments of any benefits to the office.

Submitted by _____ Date _____

Name: _____ Date: _____
Patient's Name



Feller & Feller
ORTHODONTICS

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. (The above information is a general HIPAA required statement for all health care offices).

Uses and Discloses of Protected Health Information

Your protected health information may be used and disclosed by your physician/dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's/dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician/dentist to whom you have been referred to ensure that the physician/dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for the health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's/dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician/dentist. We may also call you by name in the waiting room when your physician/dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures: Under law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician/dentist or the physician's/dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or a use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. (If applicable)

I request that my protected health information (or my child) not be disclosed to: _____

Your physician/dentist is not required to agree to a restriction that you may request. If the physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You may have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician/dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____