New Patient Intake Form

PATIENT INFORMATION

Patient's Name____

Nickname_____________________________ DOB___________________________

Address____________________________________ City___________________________ State_________ Zip__________________

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

CONTACT INFORMATION

Email______________________________________ Cell_____________________________

Other Phone Number(s) (Please indicate work, home etc)____

RESPONSIBLE PARTY INFORMATION
(Please write "same as above" where needed)

Name_____________________________________ DOB________________ Relationship to Patient__________________________

Mailing Address_______________________________City___________________________State_________Zip__________________

Residence (if different from mailing address)____

ADDITIONAL CONTACT (optional)

Name_____________________________________ DOB_____________________

Relationship to Patient___________________________ Relationship to Responsible Party________________________________

Email_____________________________________ Cell_____________________________

Other Phone Number(s) (Please indicate work, home etc)____

EMERGENCY CONTACT

Name___________________________________ Relationship to Patient______________________ Phone_____________________

Address______________________________________City____________________________State______________Zip____________

GENERAL DENTIST

General Dentist____ Month of Last Visit__________________________________

Practice Name____ City/Town____

PHYSICIAN

Physician____ Month of Last Visit__________________________________

Practice Name____ City/Town____

MEDICAL HISTORY

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 medications?____

YES NO History of a major illness?____

YES NO Has the patient had any surgeries?____

YES NO Ever been involved in a serious accident?____

YES NO Has the patient shown any sensitivity to metal (such as jewelry)?_______________________________

Female Patients Only

YES NO Has menstruation started?____

YES NO Is the patient pregnant?____

Circle any of the following 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 Hay fever	Gastrointestinal Problems	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

What concerns you most about your teeth?____

Please circle YES or NO (If YES, please fill in details)

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 there been any injuries to the face, mouth, or teeth?_____________________________

YES NO Is any part of the mouth sensitive to temperature? Where?_____________________________

YES NO Is any part of the mouth sensitive to pressure? Where?________________________________

YES NO Do gums bleed while 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? If yes, who and when?_________________________

YES NO Does the patient have a negative attitude or concerns about receiving treatment?____________

YES NO Has anyone in the family received orthodontic treatment?______________________________

How do they feel about the result?____

YES NO Do teeth or jaw ever feel uncomfortable 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 experienced chronic ringing in the ears?____________________________

YES NO Does the patient need extra help with instructions?___________________________________

YES NO Is the patient sensitive/self-conscious about his/her teeth?______________________________

YES NO Are you aware that some appointments will be during school/work hours?__________________

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Camanocha to perform a complete orthodontic evaluation.

Responsible Party Signature____Date_________________________

Doctor Signature____Date_________________________

HIPAA CONSENT FORM

I consent to the use or disclosure of my protected health information (PHI) by Southington Orthodontics for the purpose of treatment, payment, and health care operations.* I have received a copy of the Notice of Privacy Practices and understand I have a right to review prior to signing this document.

I UNDERSTAND:

- Service to me may be conditioned upon my consent as evidenced by my signature on this document.
- I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or health care operations of the practice. Southington Orthodontics is not required to agree to the restrictions that I may request. However, if Southington Orthodontics agrees to a restriction that I request, the restriction is binding on Southington Orthodontics
- I have the right to revoke this consent, in writing, at any time, except to the extent that Southington Orthodontics has taken action in reliance on this consent.
- My PHI means health information, including my demographic information, collected from me and created or received by my doctor, another health care provider, a health plan, or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me; or, there is a reasonable basis to believe the information may identify me.

THE NOTICE OF PRIVACY PRACTICES DESCRIBES:

- The types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations performed by Southington Orthodontics.
- My rights and the duties of Southington Orthodontics with respect to my PHI.

Southington Orthodontics reserves the right to change its privacy practices. For any information on current or revised notices, please call our office.

Patient Name (Please Print)____

Signature of Patient/Parent____________________________________Date:______________________

*Treatment includes activities performed by a dentist, dental assistant, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. Payment includes activities involved in paying for your treatment, billing, insurance, etc. Health care options includes the necessary administrative and business functions of our office.

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.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e. your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e. to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e. the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- 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 or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights by submitting inquiries to our Privacy Contact Person (at our office address) or the United States Secretary of Health and Human Services (must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of the right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.