Orthodontic Acquaintance Form

Date_____

Patient Name_____

Address_____

Home Phone #_____Cell #_____

Date of Birth_____School_____Grade_____

Patient's Dentist_____

Physician_____

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

Father's Name_____ Soc. Sec. #_____

Occupation_____

Employed by_____

Business address_____

Business Phone #_____ Email_____

Mother's Name_____ Soc. Sec. #_____

Occupation_____

Employed by_____

Business address_____

Business Phone # _____ Email_____

Person responsible for financial obligations_____

Do you have orthodontic insurance? _____ Dental insurance? _____

Insurance company_____

Names and ages of other children in family_____

MEDICAL HISTORY

Is patient in good health? ○Yes ○No

Have you ever been hospitalized for a serious illness? ○Yes ○No

If yes, please explain: _____

Have you ever had any of the following?

Tire easily; Weakness	○Yes	○No	Persistent fever	○Yes	○No
Marked weight change	○Yes	○No	Blood transfusion	○Yes	○No
Night sweats	○Yes	○No			

Please check any of the following for which the patient has been treated or diagnosed:

Diabetes	○Y ○N	Heart trouble	○Y ○N	Prolonged bleeding	○Y ○N
Pneumonia	○Y ○N	Rheumatic fever	○Y ○N	Fainting/dizziness	○Y ○N
Tuberculosis	○Y ○N	Bone disorders	○Y ○N	Nervous disorders	○Y ○N
Anemia	○Y ○N	Venereal disease	○Y ○N	Liver problems	○Y ○N
Epilepsy	○Y ○N	Kidney problems	○Y ○N	Psychological problems	○Y ○N
Asthma	○Y ○N	Endocrine problems	○Y ○N	Developmental disability	○Y ○N
HIV+	○Y ○N	Immunosuppression	○Y ○N		

Is there any disease, condition, or problem not listed above that you think we should know about?

If yes, please explain:_____

Do you have tendency to colds, sore throats, ear infections? ○Yes ○No

Have tonsils and adenoids been removed? ○Yes ○No

If yes, at what age? _____

List any drugs or medications now being taken, and give reasons:

_____

List any allergies or drug sensitivity_____

Has the patient reached puberty? Girls – started menstruation? ○Y ○N Boys – voice changed? ○Y ○N

Patient height_____Weight_____

Adolescent women: Are you pregnant now or think you may be? ○Yes ○No

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? ○Yes ○No

If yes, please describe: _____

Does the patient clench or grind their teeth? ○Yes ○No

Has the patient ever had any of the following?

Clicking/popping jaw? ○Yes ○No Difficulty opening/closing jaw? ○Yes ○No

Has the patient ever sucked a thumb or fingers? ○Yes ○No Until what age?_____

Does the patient have any speech problems? ○Yes ○No

Is the patient a mouth breather? ○Yes ○No While awake? ○Yes ○No While asleep? ○Yes ○No

Have you been informed of any missing or extra permanent teeth? ○Yes ○No

Has an orthodontist been consulted previously? ○Yes ○No

Has either parent had orthodontic treatment? ○Yes ○No

List any musical instruments played_____

Reason for consultation_____

Patient Signature_____

PRINT

ACKNOWLEDGEMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR

By signing below, I acknowledge that I have received the Notice of Privacy Practices from this practice.

I understand that the practice routinely mails recall postcards and may leave messages on an answering machine, voice mail, e-mail, or with another family member regarding appointments.

WITNESSES:

_____ _____

Patient or Parent Signature Date

_____ _____

Witness Signature Date

Names of Minor Children:

_____ _____

_____ _____

_____ _____

Nick S Palmer DDS, MS, PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR OBLIGATION TO OUR PATIENTS:

We are required by 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 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. You may request a copy of our Notice at any time. For more information about out 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: A) We may use or disclose your health information to a physician, dentist, or other healthcare provider (such as a specialist we refer you to) providing treatment to you. Communication with other providers is key to a successful outcome of your treatment. B) Because of our open operatory design, private consultations to discuss treatments etc, can be done upon your request

Payment: We submit claims to insurance carriers for your treatment electronically and disclose your health information to obtain payment for services we provide to you. We provide information to them regarding previous and current treatment. We may also tell an insurance company about future care in order to get prior approval or an estimate of your benefits.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. This includes assessment/review of our patient service, procedures, and improvement activities, evaluating the competence, qualifications and performance of our staff and licensed healthcare providers, 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 of 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. We will disclose health information and treatment options only to parents or guardians of minor children unless you give us prior written authorization to disclose to another party.

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 judgement 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 may notify our patients via mail about new dental procedures or products we have available. We do not share patient names or addresses with any other businesses for their marketing purposes.

Required by Law: We may use or disclose your health information when we are required to do so by law. For example, 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 general public's health or safety.

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 inmates. We may release information to a coroner, funeral director or medical examiner to identify a deceased person or as necessary to carry out their duties. If you are involved in a lawsuit, we may disclose healthcare information about you in response to a subpoena, discovery request, or court order.

Appointment Reminders: We may use or disclose your health information to provide you with appointment and premedication reminders (such as voicemail messages, answering machine, postcards, or messages left with other members of your family).

YOUR RIGHTS AS A PATIENT:

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, $20 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 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 our 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, i.e. you may request that we contact you only at your office. You must make your request in writing. Your request must specify where we should contact you, and provide satisfactory explanation how payment 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 include why the information should be amended.) We may deny your request under certain circumstances such as the information was not created by our practice or is accurate and complete as recorded.

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 believe 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 contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address to file your complaint with them upon request.

We support your right to the privacy of your health information. We will not retaliate in any way, penalize, or discriminate against you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are legally permitted. This is effective for all health information that we have about you, 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. We will always have a current notice posted in our reception area.

Contact Officer:	Sandy Unsworth
Telephone:	(248) 528-3300 (586) 978-0300
Address:	39242 Dequindre, #102, Sterling Heights, MI 48310