



Health History Form

Patient Name: _____ Date of Birth: _____

1st Parent/Guardian Name: _____ 2nd Parent/Guardian Name: _____

1st Parent/Guardian #: _____ 2nd Parent/Guardian #: _____

1st Parent/Guardian Email: _____ 2nd Parent/Guardian Email: _____

Address: _____ City _____ State _____ Zip Code _____

Dental History

Dentist Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of last cleaning: ____/____/____

Does the patient have any outstanding dental work? Yes _____ No _____

If "Yes", please explain: _____

Has the patient experienced any of the following:

- | Y | N | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bad Breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Grinding/Clenching |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Clicking/Popping Jaw |
| <input type="checkbox"/> | <input type="checkbox"/> | Periodontal Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to hot/cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Chipped teeth/Broken Fillings |
| <input type="checkbox"/> | <input type="checkbox"/> | Finger, Tongue or Thumb Habit |
| <input type="checkbox"/> | <input type="checkbox"/> | Day-time Mouth Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Snoring/Sleep Apnea |

If you checked yes to any of the above, please explain below:

Other/Details _____

Does the patient take vitamins with Fluoride? Yes _____ No _____

Medical History

Physician's Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Has the patient had any major surgeries? If so, please provide type/date:

Check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> EPILEPSY/SEIZURES/FAINTING | <input type="checkbox"/> NERVOUS DISORDERS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HERPES | <input type="checkbox"/> RHEUMATIC/SCARLET FEVER |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> HEARING IMPAIRMENT | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ABNORMAL BLEEDING | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SICKLE CELL DISEASE |
| <input type="checkbox"/> AUTISM SPECTRUM DISORDER | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> BONE DISORDERS | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> CANCER/TUMOR | <input type="checkbox"/> HEART COMPLICATIONS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> DOWN SYNDROME | <input type="checkbox"/> KIDNEY ISSUES | |

If other, please explain: _____

Allergies/Medications

Check all that apply:

- Metal/Nickel
- Latex/Rubber
- Acrylic
- Milk/Casein
- Other

If other, please explain: _____

Please list any medications patient is currently taking: _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my/the patients health.

Signature: _____

Date: _____

Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our patient information sheets before seeing the doctor.

Unless previous arrangements have been made, all payments and co-payments are due at the time of the appointment. Payment may be made by cash, check, MasterCard, Visa, Discover and American Express.

Orthodontic Benefits:

We are pleased that many of you have dental benefits and our office will assist you in obtaining the maximum benefits specified in your contract. However, your benefits are a contract between you and your insurance carrier. We will assist you in determining your benefits as best as we can because plans differ from carrier to carrier and policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Our practice is committed to providing the highest quality of treatment to our patients and we charge what is usual and customary for our area. We know how confusing insurance plans can be. If you have any questions, feel free to ask us. We may be able to help you. Our office is enrolled with several insurance companies to accept assignment of benefits, or payments, for orthodontic services. Prior to initiating orthodontic treatment your coverage will be verified and payment arrangements made for your balance.

Additional Fees

Returned Check Fee: Our bank charges us a fee for any check that is returned for "insufficient funds" and a \$35.00 fee will be added to the patient's bill if this occurs.

Aged Accounts: In the event that your account becomes delinquent for more than 60 days, you agree to pay a finance charge of 1.5% per month on any balance due, as well as reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

Appointment Policy: We respect your time and ask that you respect ours by honoring your appointment commitment. A broken appointment is a loss to everyone. Remember, once you have made an appointment, this time is reserved for you. Please give us at least 24 hours notice if you are unable to keep your appointment. This will allow us to accommodate the needs of other patients more readily. If we do not receive a cancellation notice within 24 hours, a cancellation fee of \$50 per patient (\$100 per family) may be applied to your account.

Responsible Party: For patients under the age of 18, the responsible party is the parent/guardian who accompanies the patients and completes the child(rens)'s paper work. This may or may not be the parent under whom the child is insured. Court documentation may be required in cases of divorce/separation to determine the financially responsible parent/guardian.

I have read the above **The Schulhof Center for Orthodontics** financial policy.
By my signature I acknowledge that I understand and agree abide by its terms.

Signature of Responsible Party: _____

Print Name: _____ **Date:** _____

Circle Relationship: SELF PARENT LEGAL GUARDIAN

Signature on File for Dental Insurance

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.

I authorize release of any information relating to my dental claims

X _____
Signature (Patient OR Insured Parent/Guardian) Date

I assign dental benefit payments to be paid directly to The Schulhof Center from my insurance company.

X _____
Signature (Patient OR Insured Parent/Guardian) Date



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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/1/11, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you \$0.____ for each page, \$____ per hour for staff time to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Comments

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.

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

Print name: _____ Date: _____

Signature: _____

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Authorization Form for Release of Protection Health Information

Patient(s) Name

Date of Birth

I hereby authorize the use and disclosure of individually identifiable dental health information relating to the above named patient (s) as described below. I understand that information disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Person(s) Receiving Patient's Authorized Information Include:

I understand that I may revoke this authorization at any time by notifying The Schulhof Center for Orthodontics in writing. If I choose to do so, my revocation will not affect any actions taken by The Schulhof Center for Orthodontics before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, and enrollment in health plan, or eligibility for benefits.

X _____
Signature of Patient or Patient's Personal Representative

Date

If Personal Representative _____ Relationship to Patient _____
Print Name