Insight Orthodontics

ORTHODONTIC CHILD PATIENT INFORMATION

PATIENT'S NAME: _____ **NICKNAME** _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____

ADDRESS: _____

HOME PHONE: _____ **E-MAIL:** _____

CELL PHONE: _____ **CELL PHONE CARRIER:** _____

PREFERRED METHOD OF COMMUNICATION: ___ Text ___ E-Mail ___ Phone

SCHOOL: _____ **GRADE:** _____

FATHER'S NAME: _____ **PHONE #:** _____

MOTHER'S NAME: _____ **PHONE #:** _____

PATIENT LIVING WITH: ___ Parents ___ Mother ___ Father ___ Other

Emergency Contact Name: _____

Emergency Contact Phone#: _____ **Relationship:** _____

GENERAL DENTIST: _____

MEDICAL PHYSICIAN : _____ **None**_____

REFERRED BY: _____

RESPONSIBLE PARTY NAME:_____

ADDRESS: _____

Insurance Company _____

Subscriber Name _____

Social Security Number _____

Employer _____

What are the main concerns that you would like orthodontics to accomplish?

_____

Insight Orthodontics
337 S Rancho Santa Fe Rd
San Marcos CA 92078
www.insightbraces.com

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Patient Name: _____

Has your child ever been evaluated or had orthodontic treatment before?	**Yes**	**No**
Have there been any injuries to the face, mouth, teeth or chin?	**Yes**	**No**
Have adenoids or tonsils been removed?	**Yes**	**No**
Has your child been informed of any missing or extra permanent teeth?	**Yes**	**No**
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?	**Yes**	**No**
Does your child have any problems brushing his/her teeth daily?	**Yes**	**No**
Does your child have any problems flossing his/her teeth daily?	**Yes**	**No**
Is your child currently under the care of a physician?	**Yes**	**No**
Has your child ever taken bisphosphonate drugs?	**Yes**	**No**

Has your child ever had any of the following medical problems?

Y	**N**	**Abnormal Bleeding**	**Y**	**N**	**Diabetes**
Y	**N**	**ADD/ADHD**	**Y**	**N**	**Handicaps/Disabilities**
Y	**N**	**Allergies to any Drugs**	**Y**	**N**	**Hearing Impairment**
		_____			
Y	**N**	**Allergic to Latex/Metals**	**Y**	**N**	**Heart Murmur**
Y	**N**	**Allergic to Plastic**	**Y**	**N**	**Hemophilia**
Y	**N**	**Any Hospital Stays**	**Y**	**N**	**Hepatitis**
Y	**N**	**Any Operations**	**Y**	**N**	**HIV+/AIDS**
Y	**N**	**Artifical Bones/Joints/Valves**	**Y**	**N**	**Kidney Problems**
Y	**N**	**Asthma**	**Y**	**N**	**Lupus**
Y	**N**	**Cancer**	**Y**	**N**	**Rheumatic/Scarlet Fever**
Y	**N**	**Congenital Heart Defect**	**Y**	**N**	**Sickle Cell Disease/Traits**
Y	**N**	**Convulsions/Epilepsy**	**Y**	**N**	**Tuberculosis (TB)**

Does/did your child have any of the following habits?

Y	**N**	**Clenching/Grinding Teeth**	**Y**	**N**	**Nursing Bottle**
Y	**N**	**Lip Sucking/Biting**	**Y**	**N**	**Speech Problems**
Y	**N**	**Mouth Breather**	**Y**	**N**	**Thumb/Finger Sucking**
Y	**N**	**Nail Biting**	**Y**	**N**	**Tongue Thrust**

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

_____ **_____**

Signature **Date**

Doctor Signature:_____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, Email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Signature: _____ Date: _____
Patient, Parent or Legal Guardian

If signed by patient representation, state relationship to patient: _____

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