WELCOME

Young Adult

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOU: Today's Date: ____________________

E-mail Address: ____________________

Name: ____________________
Last First Mi

Nickname: ____________________ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: ____________

School: ____________________ Grade: ____________

College: ____________________ SS #: ____________

E-mail Address: ____________________

Hobbies / Sports: ____________________

____

Home Phone: (_____)____________________

Home Address: ____________________

____
City State Zip

Whom may we Thank for referring you? ____________________

____

Previous / Present Dentist: ____________________
(Please Circle)
Last visit date: ____________

Other family members seen by us with Birthdate:

Name	Birthdate
____________________	_____/_____/_____
____________________	_____/_____/_____
____________________	_____/_____/_____

Who is responsible for making appointments?

Name: ____________________ Relation: ____________

Work Phone: (_____)____________________

Home Phone: (_____)____________________

Parent Information:

E-mail Address: ____________________

Who is accompanying you today? ____________________

Name: ____________________ Relation: ____________

Does this person have legal custody of you? ☐ Yes ☐ No

Parent's Marital Status: (Please Circle)

Single Widowed Married Divorced Separated Partnered

Mother's Information: ☐ Step Mother ☐ Guardian

Name: ____________________ Birthdate: _____/_____/_____

Wk Phone: (_____)____________ Hm Phone: (_____)____________

Employer: ____________________ SS #: ____________

How long at current job? ________ Job title: ____________

Father's Information: ☐ Step Father ☐ Guardian

Name: ____________________ Birthdate: _____/_____/_____

Wk Phone: (_____)____________ Hm Phone: (_____)____________

Employer: ____________________ SS #: ____________

How long at current job? ________ Job title: ____________

Person Responsible For Account:

Name: ____________________ Relation: ____________

Employer: ____________________ DL #: ____________

Wk Phone: (_____)____________ Hm Phone: (_____)____________

Social Security #: ____________________

Billing Address: ____________________

____
City State Zip

Previous Address: ____________________

____
City State Zip

Primary Dental Insurance:

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

____

Insurance Co. Phone #: (_____)____________________

Group # (Plan, Local or Policy #): ____________________

Policy Owner's Name: ____________________

Relationship to Policy Owner: ____________________

Policy Owner Birthdate: _____/_____/_____ SS #: ____________

Policy Owner's Employer: ____________________

Employer's Address: ____________________

____
City State Zip

Secondary Dental Insurance:

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

____

Insurance Co. Phone #: (_____)____________________

Group # (Plan, Local or Policy #): ____________________

Policy Owner's Name: ____________________

Relationship to Policy Owner: ____________________

Policy Owner Birthdate: _____/_____/_____ SS #: ____________

Policy Owner's Employer: ____________________

Employer's Address: ____________________

____
City State Zip

Why have you come to the dentist today? ______________________

____

Have you experienced problems with previous dental work? Yes No

Is your water fluoridated? Yes No

Are you taking fluoridated supplements? Yes No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)? Yes No

Do you brush your teeth daily? Yes No

Do your gums bleed? Yes No

Do you require antibiotics before dental work? Yes No

Have you ever taken Phen-Fen? Yes No

Also known as Redux or Pondimin. If so when? ______________

Are you currently under a physician's care? Yes No

Physician's Name: ______________________________

Phone #: (_____)______________ Date of last visit: __________

Please describe your current physical health: Good Fair Poor

Please list all drugs you are currently taking: ______________

____

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Unsure Week #: __________

Are you nursing? Yes No

For orthodontic treatment please complete the following:

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

____

Have you ever been evaluated/had orthodontic treatment before? Yes No

Have there been any injuries to your face, mouth, teeth or chin? Yes No

Have adenoids or tonsils been removed? Yes No

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

Do you still have your wisdom teeth? Yes No

Have you played any musical instruments? Yes No

If so, what? ______________________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Y N Aspirin
- Y N Any Metal / Jewelry
- Y N Plastic
- Y N Codeine
- Y N Dental Anesthetics
- Y N Erythromycin
- Y N Latex
- Y N Penicillin
- Y N Tetracycline
- Y N Other

Please list any other Allergies that you have ______________

____

DID/DO YOU EXPERIENCE ANY OF THE FOLLOWING?

- Y N Nursing Bottle Habits
- Y N Speech Problems
- Y N Thumb / Finger Sucking
- Y N Tongue Thrust
- Y N Clenching / Grinding Teeth
- Y N Lip Sucking / Biting
- Y N Mouth Breather
- Y N Nail Biting
- Y N Were you breastfed?
- Y N Used Pacifier

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- Y N Abnormal Bleeding
- Y N Anemia
- Y N Any Hospital Stays
- Y N Artificial Bones / Joints
- Y N Asthma
- Y N Cancer
- Y N Chicken Pox
- Y N Congenital Heart Disease
- Y N Convulsions / Epilepsy
- Y N Diabetes
- Y N Handicaps / Disabilities
- Y N Hearing Impairment
- Y N Heart Murmur
- Y N Hemophilia
- Y N Hepatitis
- Y N Hives
- Y N HIV+ / AIDS
- Y N Kidney Problems
- Y N Liver Problems
- Y N Lupus
- Y N Measles
- Y N Mononucleosis
- Y N Mitral Valve Prolapse
- Y N Rheumatic / Scarlet Fever
- Y N Skin Rash
- Y N Tuberculosis (TB)

Are your Immunizations current? Yes No

Please discuss any serious medical problems you've experienced:

____

____

Is there anything you would like to discuss with the doctor in private? Yes No

I understand that I am responsible (If 18 yrs or older) for payment of services rendered and also responsible for paying any co-payment any deductible that my insurance or my parent's insurance does not cover.

____

Patient Signature Date

____

Parent/Guardian Signature (If Necessary) Date

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

____

Signature of Patient and/or Parent/Guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

____

Signature of Patient and/or Parent/Guardian Date

The Patient or Parent/Guardian is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE

I verbally reviewed the medical / dental information above with the patient named herein. Initials: ______________ Date: _____/_____/_____

Doctor's Comments: ____

____

Family Roots DENTISTRY

FINANCIAL POLICY

Thank you for choosing us for all of your dental needs. We are committed to providing you with the highest quality of care, and we offer a variety of convenient financial options to help you receive the dental care that you need and deserve. The following information is to inform you of our financial policy.

PAYMENT OPTIONS

We accept the following methods of payment: cash, check, and credit card (VISA, MasterCard, and Discover). Please note: There is a $50 fee for all returned checks. We extend pre-payment courtesies as well as offer payment plans. We have also partnered with third-party financing companies for extended payment options.

Your expected payment is due in full at the time of service unless prior arrangements have been made. We communicate all recommended treatment options and associated fees prior to the start of treatment.

INSURANCE

Dental insurance is incredibly complex, because each insurance policy has its own unique rules and stipulations that can vary greatly and can be hard to understand. If you have dental insurance, our knowledgeable team will help you understand your specific insurance plan in order to maximize your available benefits. We are also happy to file all paperwork and claims on your behalf.

Please keep in mind that your insurance policy is a specific contract between you and your insurance company. We are not a party to that contract and cannot guarantee coverage or benefits. We do our very best to collect all the information that we can from your insurance company prior to you receiving dental care so that we can provide you with the most accurate estimates of your coverage. We kindly request that you notify our office prior to your appointment with any changes in your dental insurance policy. If the information provided is incorrect, you will be responsible for payment.

APPOINTMENTS

Your scheduled appointment is a time that we have reserved exclusively for you. We have various methods of reminding you of upcoming appointments. We understand that there may be times when you are unable to keep your scheduled appointment, and we request that you notify our office with at least 48 hours notice.

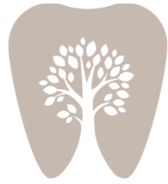
MINORS

For parents or guardians of minors, the parent or guardian that accompanies the minor to their visit assumes financial responsibility for the minor’s account.

I understand the above information and agree to its contents.

Signature: ____ DATE: ______________________

(Patient/responsible party)



Family Roots DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please note: you may refuse to sign this acknowledgement.

I have received, read, and understand this office's Notice of Privacy Practices.

Signature____ Date: ________________

____

FOR OFFICE USE ONLY

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prevented obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other

If other, please specify:
____

Date____________________________

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DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AN D HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **9/23/2013** 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as related to HIV, genetic, alcohol &/or substance abuse records and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involving your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. 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, conducting training programs and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:
-Prevent or control disease, injury or disability;
-Report child abuse or neglect;

-Report reactions to medications or problems with products or devices;
-Notify a person of a recall, repair or replacement of products or devices;
-Notify a person who may have been exposed to a disease or condition; or
-Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

National Security. We may disclose to military authorities the 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.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Dept. of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful process instituted by someone else in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out.

Other Uses & Disclosures of PHI.
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided in this Notice (or as otherwise permitted by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS
Access. You have the right to view or get copies of your PHI, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we

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maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your PHI, you must submit in writing to the Privacy Official. If you request this more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to additional requests.

Right to Request a Restriction. You have the right to request additional restriction on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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 Website or by e- mail.

QUESTIONS AND COMPLAINTS

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, if you disagree with a decision we made about access to your PHI 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 locations, you may send a complaint to us using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file this complaint 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 for the U.S. Dept. of Health and Human Services.

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