

GENERAL PATIENT INFORMATION

(PLEASE PRINT)

DATE: _____

NAME: _____ GENDER: M F DOB: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

RESPONSIBLE PARTY _____ RELATIONSHIP TO RESPONSIBLE PARTY: _____

ADDRESS FOR STATEMENTS (if different from above): _____

CITY: _____ STATE: _____ ZIP: _____ E-MAIL: _____

HAS ANY FAMILY MEMBER BEEN A PATIENT HERE? _____ NAME: _____

HAS ANY FAMILY MEMBER WORN BRACES BEFORE? _____ WHO WAS THE ORTHODONTIST? _____

WHO IS RESPONSIBLE FOR MAKING DECISIONS CONCERNING PATIENT TREATMENT? _____

WHO IS RESPONSIBLE FOR THE ACCOUNT? _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

I REALIZE IT MAY BE APPROPRIATE TO UTILIZE A CREDIT REPORT IN DETERMINING A PAYMENT PLAN.

SIGNATURE (Responsible Party): _____ DATE: _____

WHEN WAS THE LAST TIME YOU VISITED A DENTIST OFFICE? _____ DENTIST? _____

HOW MANY WAYS HAVE YOU HEARD OF OUR OFFICE? FRIEND NAME: _____

____ *Yellow Pages* ____ *Staff Member* ____ *Family Member* ____ *Previous Patient* ____ *Newspaper* ____ *Your Dentist*

____ *Television* ____ *Radio* ____ *Direct Mail* ____ *Your Company* ____ *Insurance Plan* ____ *Billboard*

MAY WE THANK SOMEONE FOR REFERRING YOU? _____ WHO? _____

IF PATIENT IS AN ADULT:

EMPLOYER: _____

SPOUSE: _____

ADDRESS: _____

EMPLOYER: _____

POSITION: _____

ADDRESS: _____

PHONE NUMBER: _____

PHONE NUMBER: _____

SOCIAL SECURITY #: _____

SOCIAL SECURITY#: _____

IF PATIENT IS A CHILD:

FATHER/STEP FATHER/GUARDIAN: _____

MOTHER/STEP MOTHER/GUARDIAN: _____

EMPLOYER: _____

EMPLOYER: _____

POSITION: _____

POSITION: _____

WORK PHONE NUMBER: _____

WORK PHONE NUMBER: _____

SOCIAL SECURITY #: _____ DOB: _____

SOCIAL SECURITY#: _____ DOB: _____

MARITAL STAUS: ____ *Married* ____ *Separated* ____ *Divorced* ____ *Widowed* ____ *Single* PATIENTS RELATIONSHIP: ____ *Birth* ____ *Adoption*

ORTHODONTIC INSURANCE INFORMATION (or Pre-paid Plan):

PRIMARY INSURANCE

POLICY HOLDER: _____

SECONDARY INSURANCE

POLICY HOLDER: _____

BIRTHDATE: _____ EMPLOYER: _____

BIRTHDATE: _____ EMPLOYER: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY: _____

INSURANCE PHONE #: _____

INSURANCE PHONE #: _____

ADDRESS: _____

ADDRESS: _____

POLICY/GROUP #: _____

POLICY GROUP #: _____

EMPLOYEE ID#: _____

EMPLOYEE ID#: _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT

DATE _____

SIGNATURE (RESPONSIBLE PARTY) _____

PATIENT: _____ DOB: _____ AGE: _____

Reason for seeking treatment: _____

Patients Dentist: _____ What would you like to change most about the appearance of your teeth? _____

Is patient's attitude toward Orthodontic treatment: Favorable? _____ Indifferent? _____ Negative? _____

Medical History: Please check Yes or No. If in doubt, leave blank.

- YES NO Are you in good health at the present time?
- YES NO Are you presently under the care of a physician for some illness or disease?
- YES NO Have you been hospitalized or had a serious illness in the last 3 years?
- YES NO Are you allergic to or had a reaction to any drugs or medications? List: _____
- YES NO Have you taken any drug or medication in the last 24 hours? If so, what? And why? _____
- YES NO Has the patient reached puberty?(Boys)-Voice change (date) _____(Girls)-Started Menstruating (approx. date)_____
- YES NO WOMEN ONLY-Are you pregnant?
- YES NO Are there any other medical or dental problems that we should know about? If so, what? _____

Do you have or have you ever had any of the following? (Please indicate yes or no).

- High/low Blood Pressure Diabetes Asthma / Hay Fever Rheumatic/Scarlett Fever
- Hearing Impairment Anemia Epilepsy Nervous Condition
- Fainting Spells/ Seizures Radiation Therapy Kidney trouble Heart Trouble or Murmur
- Arthritis Venereal Disease/ AIDS Sinus Disorder Liver Disease/ Hepatitis
- Stomach Ulcers Tuberculosis Migraines Endocrine problems
- Pain in Jaw/TMJ Prolonged Bleeding Bone Disorder

Dental History: Please check Yes or No. If in doubt, leave blank.

- YES NO Has there been any injury to the face, mouth or teeth. When? _____
- YES NO Has the patient ever sucked his/her thumb or finger? What age? _____
- YES NO Does this patient have any speech problems?
- YES NO Is this patient a mouth breather? While awake? _____ While sleeping? _____
- YES NO Have you ever been informed of any missing or extra permanent teeth? _____
- YES NO Do you have crooked teeth or do you feel that your teeth stick out too far?
- YES NO Do you like the shape and size of your teeth?
- YES NO Are you comfortable with the way your teeth fit together?
- YES NO Are you happy with the color of your teeth?
- YES NO Does food ever pack between any of your teeth when you eat?
- YES NO Are any of your teeth sensitive to hot or cold foods and drinks?
- YES NO Do your gums bleed or ever feel sore?
- YES NO Have you ever had any dental treatment to your gums?
- YES NO Do you have frequent or chronic headaches?
- YES NO Have you ever had difficulty in opening or closing your jaw?
- YES NO Do your jaws ever click or pop when chewing or opening?
- YES NO Do you clench you teeth during the day or grind your teeth at night?
- YES NO Do you ever have earaches, ringing in the ears or feel dizzy?

Signature (Responsible Party): _____ Date: _____

Doctor's Notes _____

Medical Alerts _____



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 health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 1st, 2003, 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 make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

Your child's health information and the rights associated with that health information also rest with the "personal representative" of that individual, generally the parent or legal guardian.

We use and disclose health information for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to your child.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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

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 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.

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.

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 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 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.

Abuse or Neglect: 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 health or safety of others.

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 officials having lawful custody of protected health information of 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).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of this Notice for a full explanation of time and fees involved.

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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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: 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 are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, 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 anyway if you choose to file a complaint.

Contact Officer: Robert Mitelman
Telephone: 678-445-5444 Fax: 770-874-0826
Address: 2230 Towne Lake Pkwy., Bldg 1300, Suite 100, Woodstock, GA 30189

Authorization for additional disclosure:

I am the "personal representative" of (generally parent or legal guardian) and have legal authority to make health care decisions about the following minor patient:

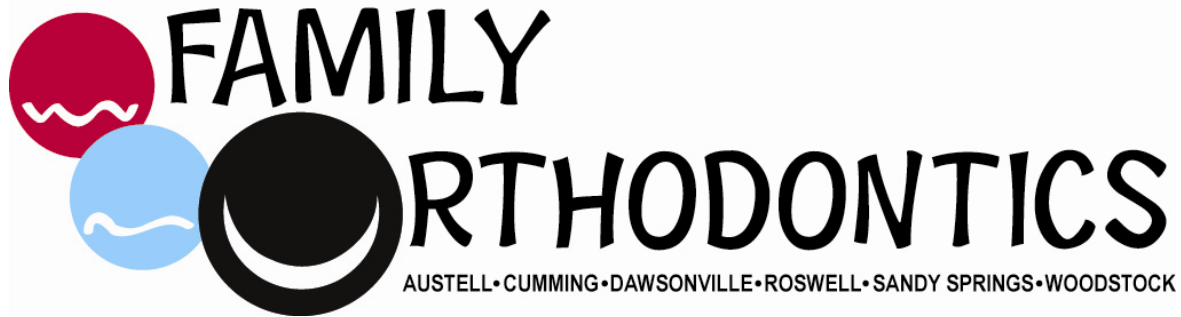
Patient Name

As the "personal representative" of the above named patient, I authorize the following individuals to accompany my child and have access to health information.

Name:	Relationship
1.) _____	_____
2.) _____	_____
3.) _____	_____
4.) _____	_____
5.) _____	_____
6.) _____	_____

"Personal Representative" (Parent or Legal Guardian)

Date



Confirmation Policy

As of June 2006, Family Orthodontics of Austell/Cumming/Dawsonville/Roswell/Sandy Springs and Woodstock P.C. has implemented a confirmation policy.

We will attempt to reach you at both a home number and an alternate number (if provided). If our attempts are unsuccessful it is your responsibility to verbally confirm all appointments either with a staff member, or on our 24 hour answering service. Please understand that without a 24 hour notice, there will be a missed appointment charge of \$25.00.

I also understand that it is my responsibility to inform the front office of any changes in my phone numbers or mailing address.

Signature

Date