

Patient Information Form (Adult)

Welcome to Dr. Cavanagh's office. We sincerely appreciate you choosing our office for your orthodontic needs. In order for us to better serve you, please complete this information form as thoroughly as possible.

Please tell us about yourself

Your Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____
Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____
Notify in case of emergency: _____

Today's Date: _____
Date of Birth: _____
Gender: M F
Home Phone #: _____
Cell Phone #: _____
Email: _____
Business Phone #: _____
Relationship to patient: _____
Emergency Phone #: _____

Person Financially Responsible

Person responsible for account: _____
Address (if different): _____
City: _____ State: _____ Zip: _____
Employer Name: _____
Occupation: _____
Do you have dental insurance? YES NO

Relationship to patient: _____
Date of Birth: _____
Home Phone #: _____
Cell Phone #: _____
Business Phone #: _____

Dental Insurance Information

Subscriber's Name: _____
Address (if different): _____
City: _____ State: _____ Zip: _____
Employer Name and Address: _____
Name of Insurance Company: _____
Identification Number of insured person: _____
SSN: _____ Group No.: _____

Relationship to patient: _____
Date of Birth: _____
Home Phone #: _____
Cell Phone #: _____
Business Phone #: _____

Do you have additional insurance? YES NO
If yes, please complete the Additional Dental Insurance Information section.

AUTHORIZATION FOR TREATMENT: This is to certify that I consent to all dental procedures agreed to between myself and Cavanagh Orthodontics and I will assume complete responsibility for all fees associated with those procedures. I authorize the insurance company indicated on this form to pay Cavanagh Orthodontics all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Cavanagh Orthodontics to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient's Signature

Date

Patient Information Form (Adult)

Patient's Name: _____

Additional Dental Insurance Information

Subscriber's Name: _____

Address (if different): _____

City: _____ State: _____ Zip: _____

Employer Name and Address: _____

Name of Insurance Company: _____

Identification Number of insured person: _____

SSN: _____ Group No.: _____

Relationship to patient: _____

Date of Birth: _____

Home Phone #: _____

Cell Phone #: _____

Business Phone #: _____

Medical / Dental History (Adult)

Your Name: _____
 Dentist's Name: _____
 Date of last visit to the dentist? _____
 Physician's Name: _____
 Date of last visit to the physician? _____

Today's Date: _____
 Dentist's Phone #: _____
 Physician's Phone #: _____

MEDICAL History

Please tell us if you have had any of the following by checking the appropriate boxes:

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Please list any ALLERGIES: _____

Please list any other MEDICAL CONDITIONS not mentioned above: _____

Please list all MEDICATIONS you are currently taking: _____

(Include the dose and frequency) _____

DENTAL History

Please tell us if you have had any of the following by checking the appropriate boxes:

Permanent or "extra" teeth removed _____ Congenitally missing teeth _____ Injuries to the teeth, face, or jaws (circle which) _____ Bleeding gums, bad taste, or mouth odor (circle which) _____ Been treated for periodontal disease _____ Food traps between the teeth _____ Thumb / finger sucking habit. Until age _____ Tongue thrust swallowing habit _____ Mouth breathing habit / snoring _____ Speech problems _____	<table border="0" style="width: 100%;"> <tr><td style="text-align: center;">Y</td><td style="text-align: center;">N</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	Y	N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nail biting habit _____ Play a musical instrument _____ Clench or grind teeth (circle which) _____ Pain / soreness in the muscles of the face _____ Been treated for "TMJ" _____ Loose or broken dental fillings _____ Wisdom tooth problems _____ Any relative with a similar bite _____ Prior orthodontic evaluation / treatment _____ Ever had an unpleasant dental experience _____	<table border="0" style="width: 100%;"> <tr><td style="text-align: center;">Y</td><td style="text-align: center;">N</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	Y	N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Why are you interested in seeking orthodontic treatment? _____

I have read and understand the above questions. I will not hold Dr. Cavanagh or any member of her staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes later to this history record or medical / dental status, I will so inform the practice.

Patient's Signature

Date

Privacy Consent

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's (Parent's/Guardian's) Signature

Print Name

Date

Privacy Notice

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

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice

provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient's (Parent's/Guardian's) Signature

Date