Patient Information Form (Child)

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 your child

Patient's Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

School: _____ Gender: M F

Hobbies / Sports: _____ Home Phone #: _____

Whom may we thank for referring you? _____ Emergency Phone #: _____

Notify in case of emergency: _____

If the patient is a minor, please tell us about you, the parent or guardian: Relationship to patient: _____

Your Name: _____ Home Phone #: _____

Your Address (if different): _____ Cell Phone #: _____

City: _____ State: _____ Zip: _____ Email: _____

Person Financially Responsible

Person responsible for account: _____ Relationship to patient: _____

Address (if different): _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Home Phone #: _____

Employer Name: _____ Cell Phone #: _____

Occupation: _____ SSN: _____ Business Phone #: _____

Do you have dental insurance? YES NO

Dental Insurance Information

Subscriber's Name: _____ Relationship to patient: _____

Address (if different): _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Home Phone #: _____

Employer Name and Address: _____ Cell Phone #: _____

_____ Business Phone #: _____

Name of Insurance Company: _____

Identification Number of insured person: _____ Do you have additional insurance? YES NO

SSN: _____ Group No.: _____ If yes, please complete the Additional Dental Insurance Information section.

AUTHORIZATION FOR TREATMENT: This is to certify that I, the undersigned Parent / Guardian, 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 resposible for all charges whether or not paid by insurance.

_____ _____

Parent's / Guardian's Signature **Date**

Patient Information Form (Child)

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 (Child)

Patient's Name: _____ Today's Date: _____

Dentist's Name: _____ Dentist's Phone #: _____

Date of last visit to the dentist? _____

Physician's Name: _____ Physician's Phone #: _____

Date of last visit to the physician? _____

MEDICAL History

Please tell us if your child has had any of the following by checking the appropriate boxes:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Bone Fractures	☐	☐	Pneumonia	☐	☐	Eating Disorders	☐	☐	Artificial Heart Valve(s)
☐	☐	Major Accidents	☐	☐	Immunosuppressive			(Anorexia / Bulimia)	☐	☐	Congenital Heart Lesion
☐	☐	Rheumatoid or Arthritic			Disorders	☐	☐	Anemia / Blood Problems	☐	☐	Heart Surgery
		Conditions	☐	☐	AIDS / HIV Positive	☐	☐	Hemophilia	☐	☐	Frequent Headaches
☐	☐	Endocrine or Thyroid	☐	☐	Liver Problems	☐	☐	Excessive Bleeding	☐	☐	Frequent Colds or
		Problems	☐	☐	Hepatitis	☐	☐	High / Low Blood Pressure			Sore Throat
☐	☐	Kidney Problems	☐	☐	Fainting	☐	☐	Tire Easily	☐	☐	Ear, Nose, or Throat
☐	☐	Diabetes	☐	☐	Neurological Problems	☐	☐	Chest Pain			Condition
☐	☐	Cancer, Tumors, Growths	☐	☐	Epilepsy / Seizures	☐	☐	Shortness of Breath	☐	☐	Hay Fever
☐	☐	Radiation Treatment or	☐	☐	Psychiatric Problems	☐	☐	Persistent Cough	☐	☐	Sinus Problems
		Chemotherapy	☐	☐	Emotional Problems	☐	☐	Cardiovascular Problems	☐	☐	Asthma
☐	☐	Ulcer / Colitis	☐	☐	Vision Disorders	☐	☐	Heart Murmur	☐	☐	Respiratory Disease
☐	☐	Mononucleosis	☐	☐	Hearing Disorders	☐	☐	Mitral Valve Prolapse	☐	☐	Skin Disorder
☐	☐	Tuberculosis	☐	☐	Speech Disorders	☐	☐	Rheumatic Fever	☐	☐	Fever Blisters

Please list any ALLERGIES: _____

Please list any other MEDICAL CONDITIONS not mentioned above: _____

Please list all MEDICATIONS your child currently takes: _____

(Include the dose and frequency) _____

DENTAL History

Please tell us if your child has had any of the following by checking the appropriate boxes:

	Y	N		Y	N
Started teething very early or late (circle which)	☐	☐	Speech problems _____	☐	☐
"Baby" teeth removed that were not loose	☐	☐	Mouth breathing habit / snoring	☐	☐
Permanent or "extra" teeth removed _____	☐	☐	Nail biting habit	☐	☐
Congenitally missing teeth _____	☐	☐	Play a musical instrument _____	☐	☐
Injuries to the teeth, face, or jaws (circle which)	☐	☐	Clench or grind teeth (circle which)	☐	☐
Bleeding gums, bad taste, or mouth odor (circle which)	☐	☐	Pain / soreness in the muscles of the face	☐	☐
Been treated for periodontal disease	☐	☐	Loose or broken dental fillings	☐	☐
Food traps between the teeth	☐	☐	Any relative with a similar bite _____	☐	☐
Thumb / finger sucking habit. Until age _____	☐	☐	Prior orthodontic evaluation / treatment	☐	☐
Tongue thrust swallowing habit	☐	☐	Ever had an unpleasant dental experience	☐	☐

Why are you interested in orthodontic treatment for your child? _____

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.

_____ _____

Parent's / Guardian'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