Foundations ORTHODONTICS

New Patient Questionnaire for Child or Teen

Welcome to the office of Drs. William Bennett and Jeffrey Crews. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible for your child. We look forward to meeting you!

Patient Information

Last Name _____ First name _____ Middle _____

I prefer to be called (Nickname) _____ Gender Male Female

Birth date (MM-DD-YYYY) _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

Email _____ School _____ Grade _____

Patient siblings (Name and age) _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Responsible Party Last Name _____ First Name _____

Residential Address _____ City _____ State _____ Zip _____

How long at this address _____ Home Ph. _____ Work Ph. _____ Cell Ph. _____

Previous Address (if less than 3 yrs) Street _____

City _____ State _____ Zip _____

Birth date (MM-DD-YYYY) _____ Social Security # _____ Email _____

Relationship to Patient _____ Employer _____

Occupation _____ Number of years employed with above employer _____

Spouse's Last Name _____ First Name _____

Address (if different) _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Other Phone _____

Birth date (MM-DD-YYYY) _____ Social Security # _____ Email _____

Relationship to Patient _____ Employer _____

Occupation _____ Number of years employed with above employer _____

Other adults/relatives or guardians we should know about

Last Name _____ First Name _____

Relationship to Patient _____ Phone _____ Email _____

Emergency Information

Who should we notify in case of emergency _____ Phone _____

Relationship to patient _____

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Dental Insurance Information

Primary Policy Holder's Name _____ Social Security # _____ DOB _____

Insurance Company _____ Group # _____ ID # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Medical History

Physician _____ Phone _____ Date of Last Visit _____

Address _____

Please fill out the following fields and elaborate as necessary:

Yes	No	Is there a current medical problem? _____
Yes	No	Is the patient taking any pills, medications, or drugs? _____
Yes	No	Is the patient allergic to any medications or anesthetics? _____
Yes	No	Is the patient allergic to latex?
Yes	No	Is the patient allergic to anything else? _____
Yes	No	Has the patient had a serious illness? _____
Yes	No	Has the patient had any surgery or been hospitalized? _____
Yes	No	Has the patient ever had an injury to the head, face, or mouth? _____
Yes	No	Has patient's tonsils and/or adenoids been removed? _____
Yes	No	Does the patient snore? _____
Yes	No	Is patient sleepy during the day? _____

Please circle any of the following conditions the patient has had or currently has:

Abnormal/Prolonged Bleeding	Pneumonia	Psychiatric Care
Anemia/Blood Disease	Nervousness / Anxiety	Immune System Problems
Arthritis	Radiation / Chemotherapy	High Blood Pressure
Asthma	Rheumatic Fever	Sinus Trouble
Cancer	Tuberculosis	Fainting
Congenital Heart Defect	Tumor or other growths	Bone Disorders
Diabetes	Stomach Ulcers	Thyroid / Parathyroid Problems
Dizziness	Tonsillitis	Endocrine Problems
Epilepsy / Seizures	Herpes	Frequent Headaches
Heart Problems	HIV / AIDS	Hepatitis/Liver Problems
Heart Murmur	Kidney Problems	Gastrointestinal Disorders

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

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Dental History

Who is the patient's dentist? _____

When was the patient last seen by a dentist? _____

What was the reason for the visit? _____

Has any member of the family had orthodontic treatment? _____

What are your main concerns about your child's teeth and what would you like orthodontics to accomplish?_____

_____

Has/Does the patient:

Yes No Had trouble associated with dental treatment? _____

Yes No Had a previous orthodontic treatment or consultation?

With whom? _____ When _____

Yes No Had any teeth extracted? Why? _____

Yes No Ever injured or broken any teeth? When/what happened? _____

Yes No Ever injured the head or face? When/what happened? _____

Yes No Had any problems with eating, chewing, or swallowing? _____

Yes No Ever sucked thumb fingers bit nails? Until what age? _____

Yes No Have dental or facial pain? _____

Yes No Hear a noise when opening/closing jaw joints?_____

Yes No Feel pain in jaw joints? _____

Yes No Have uncomfortable teeth or jaws first thing in the morning? _____

Yes No Clench or grind teeth? _____

Yes No Experience tension headaches? _____

Yes No Have speech problems?_____

Yes No Normally breathe with lips parted? _____

Yes No Have swellings or growths in mouth or face?_____

Yes No Have periodontal (gum) disease? _____

Yes No Have any negative or resistant feelings about orthodontic treatment?_____

Yes No Have dissatisfaction with appearance of the teeth? _____

Yes No Have resistant feelings toward: Braces Headgear Retainers

Is there any other information we should know?_____

_____

I understand that the information that I have provided 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 medical, dental, or insurance status. I understand that I am responsible for payment of services rendered and for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the release of any information related to insurance claims. I consent to the examination by Dr. Bennett, Dr. Crews, and/or their representatives and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained for the purpose of considering payment options.

Responsible Party Signature _____ Date_____

Foundations ORTHODONTICS

Notice of Privacy Practices Acknowledgement

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 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

We use and disclose health information about you 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 you.

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 disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use 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.

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National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.)

Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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.

If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost for responding to these requests.

Restriction: You have the right to request that we place additional restrictions on our use and 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (**You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: You are entitled to receive this notice on our Web site or by electronic mail.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

Contact: Foundations Orthodontics • Dr. William Bennett and Dr. Jeffrey Crews

Telephone: (706) 291-2901

E-Mail: foundortho@gmail.com

Address: 317 Redmond Rd NW, Rome, Georgia 30165

Website: www.FoundOrtho.com

I have received a copy of this office's Notice of Privacy Practices.

_____ _____

(Please Print Name) (Signature)

_____ _____

(Patient Name) (Date)