# Confidential Patient Information Form

## CHILD

PT #: ________________
DATE: ________________

MALE ____ FEMALE ____

PATIENT NAME: ______________________ BIRTHDATE: ____________ PH: ____________

ADDRESS: ______________________ CITY: ____________ ST: ______ ZIP: ________

DENTIST: ______________ DATE OF LAST VISIT: ________ SCHOOL: ____________ GRADE: ________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

IN YOUR OWN WORDS, WHAT IS THE PROBLEM? ______________________________

HAVE YOU SEEN ANOTHER ORTHODONTIST? ______ WHO? ____________ ANY TREATMENT? ____________

ANY FAMILY MEMBERS TREATED HERE? ________ WHO? ______________ RELATIONSHIP: ____________

*CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR STILL HAVE AT PRESENT:*

- ☐ BABY TEETH REMOVED
- ☐ PERMANENT TEETH REMOVED
- ☐ TONGUE THRUST
- ☐ SPEECH PROBLEMS
- ☐ THUMB/FINGER SUCKING
- ☐ LIP BITING
- ☐ NAIL BITING
- ☐ TEETH CLENCHING
- ☐ TEETH GRINDING
- ☐ DIFFICULTY OPENING WIDE
- ☐ CLICKING OR POPPING JAWS
- ☐ PERIODONTAL CARE
- ☐ EARACHES
- ☐ FREQUENT HEADACHES
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART MURMUR
- ☐ ANEMIA/BLOOD DISORDER
- ☐ ASTHMA
- ☐ SINUS
- ☐ DIFFICULTY BREATHING THROUGH NOSE
- ☐ EPILEPSY OR SEIZURES
- ☐ FAINTING/DIZZY SPELLS
- ☐ TONSILS/ADENOIDS REMOVED
- ☐ ALLERGIES __________
- ☐ KIDNEY TROUBLE
- ☐ DRUG ADDICTION
- ☐ PROLONGED BLEEDING
- ☐ VENEREAL DISEASE
- ☐ HEPATITIS A, B, C
- ☐ AIDS/HIV
- ☐ CHEW TOBACCO
- ☐ SMOKE TOBACCO

ANY OTHER SERIOUS HEALTH DISORDER WE SHOULD KNOW ABOUT? ______________________________

ANY MEDICATIONS TAKEN REGULARLY? ______________________________

WHAT DO YOU EXPECT FROM ORTHODONTIC TREATMENT? ____________________ CONCERNS? ____________

## PARENT/GUARDIAN INFORMATION

NAME: ______________ RELATIONSHIP: __________ SS#: __________ BIRTHDAY: __________

ADDRESS: ______________ EMAIL ADDRESS: ______________ PHONE: __________

ARE YOU ?
___ MILITARY
___ TEACHER
___ POLICE
___ FIRE

NAME: ______________ RELATIONSHIP: __________ SS#: __________ BIRTHDAY: __________

ADDRESS: ______________ EMAIL ADDRESS: ______________ PHONE: __________

ARE YOU ?
___ MILITARY
___ TEACHER
___ POLICE
___ FIRE

## ORTHODONTIC INSURANCE INFORMATION

*PRIMARY*

SUBSCRIBER: ______________ SS# ______________ BIRTHDATE: __________

INSURANCE CO: ______________ GROUP #: ______________ ID #: __________

INSURANCE PHONE: ______________ ADDRESS: ______________________

*SECONDARY*

SUBSCRIBER: ______________ SS# ______________ BIRTHDATE: __________

INSURANCE CO: ______________ GROUP #: ______________ ID #: __________

INSURANCE PHONE: ______________ ADDRESS: ______________________

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING INFORMATION IS TRUE AND CORRECT. IF MY HEALTH CHANGES, OR MY MEDICATIONS CHANGE, I WILL INFORM THE OFFICE AS SOON AS POSSIBLE.

SIGNATURE: ______________________________ DATE: ______________

PATIENT ________________________________________ DATE ___________

**TEMPOROMANDIBULAR JOINT AND FACIAL-QUESTIONNAIRE**

**Please check all categories below – feel free to ask for assistance if you do not understand any question.**

| YES | NO | Section #1 |
|---|---|---|
| ___ | ___ | Does your jaw make noise so that it bothers you or others? |
| ___ | ___ | Does your jaw get stuck as you Try to open? |
| ___ | ___ | Does it hurt when you chew or open wide to take a big bite? |
| ___ | ___ | Do you have earaches or pain in front of the ears? |
| ___ | ___ | Do you have pain in the face, cheeks, jaws, throat or temples? |
| ___ | ___ | Is it difficult for you to open your mouth as far as you want to? |
| ___ | ___ | Do you suffer from frequent headaches? |
| ___ | ___ | Does your jaw “feel tired” after a big meal or dental visit? |
| ___ | ___ | Are you aware of an uncomfortable or bad bite? |

| YES | NO | Section #2 |
|---|---|---|
| ___ | ___ | Are you aware that you grind your teeth at night or during the day? Circle: Day Night |
| ___ | ___ | Do you have a habit of clamping or clenching (“setting”) your teeth? Circle: Day Night |
| ___ | ___ | Do you have any jaw symptoms or headache upon Waking in the A.M.? |
| ___ | ___ | Must you chew excessively on one side? |
| ___ | ___ | Have you had a blow to the jaw (trauma)? |
| ___ | ___ | Are you a habitual gum-chewer? |

| YES | NO | Section #3 |
|---|---|---|
| ___ | ___ | Does the pain or discomfort disturb your sleep? |
| ___ | ___ | Does the pain or discomfort interfere with your daily routine or other activities? |
| ___ | ___ | Do you take medications or pills for pain or discomfort? (pain relievers, muscle relaxants) |
| ___ | ___ | Does the pain or discomfort affect your appetite? |
| ___ | ___ | Do you feel the pain or discomfort extremely frustrating or depressing? |

| YES | NO | Section #4 |
|---|---|---|
| ___ | ___ | Do you suffer from arthritis or pain in other joints? |
| ___ | ___ | Do you suffer from stomach or ulcers? |
| ___ | ___ | Do you suffer from back or neck pain (whiplash)? |
| ___ | ___ | Do you suffer from skin problems or allergies? |
| ___ | ___ | Have you ever been treated for jaw muscle or jaw joint disorders? |

______________________________________________ ____________________

Signature Date

______________________________________________ ____________________

Office Witness Date

418 E. 30th Ave.
Spokane, WA 99203

HI 5 ORTHODONTICS

9425 N. Nevada, Ste. 100
Spokane, WA 99218

# 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 carefully. The privacy of your health information is important to us.**

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**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 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 4.14.2003 and will remain in effect until we replace it.

We reserve the right to change our privacy and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practice 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 a new notice available.

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.

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**Uses and Disclosure 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 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 your health information for any reason except those described in this notice. Your written authorization is good from the date that you signed the HIPAA form (Acknowledgment of Privacy Practices) through the end of your treatment or your child's or guardianship's treatment unless withdrawn by you.
**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 of 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 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 and safety or the health and 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 official 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, text messages, email 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 feasibly 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge no more than $1.09 for the first 30 pages and no more than $ .82 for each page thereafter, and postage if you want the copies mailed to you. We may charge a $24 clerical fee for research and handling of records. If you request an alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. 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, for the last 6 years, but not before April 14th, 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.

**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 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.

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## QUESTIONS AND COMPLAINTS

If 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 or in response to a request you made to amend or restrict the use or disclosure of your health information or have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed 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 your complaint with the U.S. Department of Health and Human Services.


**Contact Officer:** Selena Fenton

**Telephone:** 509-232-7223 Fax: 509-325-5949

**Email:** management@shareyoursmile.com

**Address:** 9425 N. Nevada, Ste. 100, Spokane, WA 99218

HI 5 ORTHODONTICS

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____________________________________

I ____________________________, have received a copy of this office's Notice of Privacy Practices.
(Print Responsible Party Name)

_____________________________________________________________________________
(Responsible Party Signature) (Date)

May we leave a detailed voice mail message?____Yes ____No If so, what number? ____Home____ Cell ____ Both

*Please note, it is your responsibility to notify our office of phone number changes or if you wish to revoke this authorizations for detailed messages to be left.

Please list individuals with whom we may share PHI (Personal Health Information) of the above named patient with:

Name: __________________________________ Relationship: ________________________

Name: _________________________________ Relationship: _________________________

** Your signature gives us permission to share PHI (Personal Health Information) with the above-named individual(s) for the period of the date of this form through the end of your active treatment***

**For Official Use Only**

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____________________________________________________________________________

_____________________________________________________________________________

# Hi 5 ORTHODONTICS

Name: ________________ I like to be called: __________________

## WHAT MAKES YOU SMILE?

________________________________________________________________________

## ALL ABOUT ME

Hi 5 Orthodontics wants to know more about you!

### HOBBIES

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### MUSIC GROUPS

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### sports

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### PETS

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## I'M *REALLY* GOOD AT: ______________________________

MY FAVORITE SUBJECT IN SCHOOL IS: ______________________

Favorite Charity: __________________________

FAVORITE MOVIE: ________________________