SUSANVILLE
ORTHODONTICS & PEDIATRIC DENTISTRY

Date _____

Confidential Patient Information

Patient's Name #1 _____ DOB:_____ Gender: _____

Patient's Name #2 _____ DOB:_____ Gender: _____

Patient's Name #3 _____ DOB:_____ Gender: _____

Patient's Name #4 _____ DOB:_____ Gender: _____

Patient's Name #5 _____ DOB:_____ Gender: _____

Address _____
Street City State Zip

Home Phone _____

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

☐ Billboard ☐ Social Media ☐ Friend ☐ Family Member

☐ Current Patient-Name of Patient: _____

☐ School: _____

☐ Other: _____

Confidential Responsible Party Information

Parent/Guardian Name _____ Marital Status _____
Last First Middle

Residence ☐ Same as Patient

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Parent/Guardian Name _____ Rel. to Patient _____
Last First Middle

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

Susanville Orthodontics & Pediatric Dentistry Confidential Patient Medical and Dental History

REMINDER: Each child will need a separate Patient Medical and Dental History form. Extra forms can be found on our website under the 'forms' tab labeled Medical History Form.

Patient _____ Date of Birth _____

Physician's Name _____ Phone _____ Last Visit _____

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Heart Conditions (murmur, etc.)	☐ HIV Positive	☐ Hepatitis
☐ Excessive Bleeding	☐ Tuberculosis	☐ Frequent Headaches
☐ Diabetes	☐ Asthma	☐ Kidney Infections
☐ Rheumatic Fever	☐ Epilepsy	☐ Cerebral Palsy
☐ Liver Problems	☐ Birth Defects	☐ Eyesight Problems
☐ Cancer	☐ Infections	☐ Speech Impairments
☐ Nervous Disorders	☐ ADHD	☐ Autism

☐ Other _____

Is the patient currently on any medications? ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any foods or medicines? ☐ Yes ☐ No If yes, list: _____

Last Dentist's Name _____ Phone _____ Last Visit _____

DENTAL AND ORTHODONTIC HISTORY

Were any x-rays taken at patient's last dental visit? ☐ Yes ☐ No _____

Has patient had any problems with dental exams or treatment in the past? ☐ Yes ☐ No _____

Has patient had any cavities in the past? ☐ Yes ☐ No _____

Does patient brush their teeth daily? ☐ Yes ☐ No _____

Does patient currently take a fluoride supplement tablet, gels, rinses, etc.? ☐ Yes ☐ No _____

Does patient floss their teeth daily? ☐ Yes ☐ No _____

Has patient ever received local anesthetic? ☐ Yes ☐ No _____

Has patient ever had sealants placed? ☐ Yes ☐ No _____

If applicable: Has parent been diagnosed with tooth decay in past two years? ☐ Yes ☐ No _____

Has patient experienced any trauma to the teeth? (falls, blows, chips, etc.) ☐ Yes ☐ No _____

If yes, please explain: _____

Please describe patient's diet (regular/favorite foods) _____

Has patient ever sucked thumbs or fingers? ☐ Yes ☐ No _____

Does patient have speech problems? ☐ Yes ☐ No _____

Has patient ever been informed of any extra or missing teeth? ☐ Yes ☐ No _____

Has patient ever had a previous orthodontic exam? ☐ Yes ☐ No _____

Have any family members ever needed orthodontics in the past? ☐ Yes ☐ No _____

Does patient have any pain in their jaw? ☐ Yes ☐ No _____

Does patient have any popping or clicking of the jaw joint? ☐ Yes ☐ No _____

Any orthodontic concern? _____

Please tell us about the patient's interests (favorite sports, hobbies, TV shows, travel, movies, etc.)

_____

Thank you for taking the time to fill this out!

I certify that the above information is complete and accurate.

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

INSURANCE INFORMATION:

Student #1 . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)
_____ (CITY) _____ (STATE) _____ (ZIP)

Student #2 . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)
_____ (CITY) _____ (STATE) _____ (ZIP)

Student #3 . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)
_____ (CITY) _____ (STATE) _____ (ZIP)

Student #4 . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)
_____ (CITY) _____ (STATE) _____ (ZIP)

Student #5 . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)
_____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)
Relationship _____ DOB _____ Sex: ❑ M ■ F
Mailing Address _____
City _____ State _____ Zip _____
Social Security # _____
Home Tel. (_____) _____ Cell. (_____) _____
Custody / Court Order in Place? ❑ Yes ■ No
Employer _____
Group Name _____
Insurance Company _____
ID # _____ ❑ PPO ❑ HMO

PRIMARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)
Relationship _____ DOB _____ Sex: ❑ M ❑ F
Mailing Address _____
City _____ State _____ Zip _____
Social Security # _____
Home Tel. (_____) _____ Cell. (_____) _____
Custody / Court Order in Place? ❑ Yes ❑ No
Employer _____
Group Name _____
Insurance Company _____
ID # _____ ❑ PPO ❑ HMO

SECONDARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)
Relationship _____ DOB _____ Sex: ❑ M ❑ F
Mailing Address _____
City _____ State _____ Zip _____
Social Security # _____
Home Tel. (_____) _____ Cell. (_____) _____
Custody / Court Order in Place? ❑ Yes ❑ No
Employer _____
Group Name _____
Insurance Company _____
ID # _____ ❑ PPO ❑ HMO

SECONDARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)
Relationship _____ DOB _____ Sex: ❑ M ❑ F
Mailing Address _____
City _____ State _____ Zip _____
Social Security # _____
Home Tel. (_____) _____ Cell. (_____) _____
Custody / Court Order in Place? ❑ Yes ❑ No
Employer _____
Group Name _____
Insurance Company _____
ID # _____ ❑ PPO ❑ HMO

Susanville Pediatric Dentistry

Our Mission: "Quality Care and a Positive Patient Experience"

The doctors and staff at Susanville Pediatric Dentistry have an unwavering commitment to your child's superior oral health. We use sound scientific and ethical principles in order to provide your child with the highest standard of pediatric dental care available in our area. We also recognize that creating a fun, friendly, and comfortable environment is critical to the child's long-term oral health. We know you have a choice in dental providers and we hope that these goals are the primary reasons you have chosen our practice. Please keep in mind that all of the following policies center on accomplishing these two core philosophies.

Late Appointment Policy

We ask that all parents make a special effort to be at their child's appointments on time in order to minimize the impact on their child's care and dental experience as well as that of those patients scheduled later in the day. If a patient is more than 10 minutes late to a 30 minute appointment or 15 minutes late to a 60 minute appointment they may be required to reschedule or wait while we care for those patients who were on time to their appointments. Regular tardiness will lead to the end of the doctor-patient relationship.
INITIAL_____

Missed or Cancelled Appointment Policy

Due to the busy nature of our practice and as a common courtesy to the doctors and staff who are providing important care to your child, we ask that you please make your child's appointment a top priority. If you are unable to make your appointment please give us sufficient time to fill your child's appointment with another child waiting to see the doctor. We ask that you call to reschedule or cancel 48 hours in advance, in order to avoid a $50 fee. A second last minute cancellation or no-show can lead to the end of the doctor-patient relationship.
INITIAL _____

Insurance and Financial Policy

In most cases insurance companies do not pay for 100% of the care needed by our patients. Should there be a difference between the costs of the dental care provided to your child by Susanville Pediatric Dentistry and the amount your insurance company reimburses the difference will be your responsibility. At your request, we will do all we can to help you understand and maximize the benefits available to you through your insurance provider, but ultimately it is your responsibility to understand the coverage of your policy prior to care being provided and charges incurred.
INITIAL _____

Communication

Our top priority is to give you all the information needed to make informed decisions in regards to your child's oral health. This includes providing you with the nature of recommended procedures, the risks of those procedures, any alternatives to the procedures recommended, and an estimate of the costs involved to perform those procedures.

We hope that open communication is important to you as well and that any concerns you have about treatment or our policies will be brought immediately to our attention with the same courtesy and respect. We will sincerely do all we can to develop a long-term relationship where your child's oral health and dental experience is number one for both of us.

I have read, understand, and agree to Susanville Pediatric Dentistry's key practice policies.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Printed Name Relationship to Patient(s)

☐ I acknowledge that I recieved a copy of Susanville Pediatric Dentistry Notice of Privacy Practices.

_____ _____
Patient/Parent Name Date

_____
Signature

January 1, 2018

NOTICE OF PRIVACY PRACTICES

Susanville Orthodontics & Pediatric Dentistry

151 Ash Street, Ste B,
Susanville, CA 96130
info@susanvilleorthodontics.com

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call, email, text or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, email, text, or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for any other reason we will request your written.

SUSANVILLE
ORTHODONTICS & PEDIATRIC DENTISTRY

I, _____ , give my permission for Susanville Orthodontics & Pediatric dentistry to perform dental procedures including nitrous and local anesthetic within the professional scope of dentistry deemed as necessary on my child/children to individuals with my permission. I give my permission to the following individuals to bring in my child/children to Susanville Orthodontics & Pediatric Dentistry for their appointments that may include any and all dental procedures.

Patient Name #1

Patient Name #2

Patient Name #3

Patient Name #4

Patient Name #5

Relationship to the Patient(s)

I, _____ , acknowledge the understanding that dentistry is not an exact science and herby request and authorize whatever the doctor deems advisable if any unforeseen condition arises in the course of these designated treatment(s) and/or procedures calling, in their judgment, for procedures in addition to or different from those contemplated. In addition, I have provided as accurate and complete medical history as possible including those antibiotics, drugs, medications and foods to which my child is allergic.

Legal Guardian Name

Signature

Date

SUSANVILLE
ORTHODONTICS & PEDIATRIC DENTISTRY

Your Name: _____ **Today's Date:** _____

Relationship to Patient(s): _____ **Patient(s) Name:** _____

_____

_____

_____

_____

How would you like us to communicate with you?

Our office sends appointment reminders, information about treatment, payment and insurance, and other communications including but not limited to newsletters, events, etc. Please tell us how you would like us to communicate with you.

Check or complete all that apply (please print clearly):

☐ Contact me by U.S. Mail at the following address: _____

☐ Contact me by email at the following email address: _____

For Phone Communications:

This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our office.

Phone Number: _____

☐ **By checking this box, I consent to the following:** The practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

☐ Call me

Signature: _____ Date: _____

Please call right away if you get a new telephone number!

For Office Use Only:

☐ Consent revoked. Date/Initials: _____/_____

☐ Possible reassigned number. Date/Initials: _____/_____

☐ Confirmed accurate.

Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____ (your name) have received a copy of this office's Notice of Privacy Practices.

_____

_____

_____

_____

_____

(Please Print Patient Name)

_____

(Your Signature)

_____

(Date)

FOR OFFICE 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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

_____

SUSANVILLE
ORTHODONTICS & PEDIATRIC DENTISTRY

PHOTOGRAPH/VIDEO RELEASE

I grant permission to Susanville Orthodontics to use photographs/video taken of me and the use of my name for use in the No Cavity Club, web page, Facebook and blog.

I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release.

_____

Signature

_____

Signature of parent/guardian if under age of 18

_____

Date

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ORTHODONTICS & PEDIATRIC DENTISTRY

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Signature of parent/guardian if under age of 18

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Date

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Signature

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Signature of parent/guardian if under age of 18

_____

Date

SUSANVILLE
ORTHODONTICS & PEDIATRIC DENTISTRY