Gorman & Bunch Orthodontics - West Carmel and Zionsville, IN

Patient Name ______________________ Date ______________________

Patient's Birth Date ______________________ Family Dentist ______________________

Family Physician ______________________

PLEASE CHECK ALL THAT APPLY

DENTAL HISTORY

Yes

- ☐ Has patient ever sucked thumb or finger?
- ☐ Does patient suck thumb or finger now?
- ☐ Does patient have any speech problems?
- ☐ Does patient have any difficulty in chewing food?
- ☐ Does patient clinch or grind teeth?
- ☐ Does patient have any pain in the jaws?
- ☐ Does patient have clicking or popping when opening mouth?
- ☐ Does patient have bleeding gums?
- ☐ Has the patient had any head or facial injuries? If yes, please describe: ______________________
- ☐ Has the patient had any previous orthodontic treatment? (Braces, retainters, etc.) If yes, please describe: ______________________
- ☐ Is the patient embarrassed about the appearance of his or her teeth?
- ☐ Have any other family members had orthodontic treatment?

MEDICAL HISTORY

Has patient ever had any of the following?

Yes

- ☐ Reaction to any medication
- ☐ Nickel sensitivity and/or allergy
- ☐ Latex sensitivity and/or allergy
- ☐ Other allergies? Please list: ______________________
- ☐ Sinus problems
- ☐ Tonsils or adenoids removed
- ☐ Bleeding problems
- ☐ Frequent sore throat
- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ Hepatitis
- ☐ AIDS or HIV positive
- ☐ Dizziness or fainting
- ☐ Frequent headaches
- ☐ Arthritis
- ☐ Diabetes
- ☐ Snoring/Sleep Apnea
- ☐ Is the patient's general health good? If no, please explain: ______________________
- ☐ Is the patient presently under a physician's care? If yes, please explain: ______________________
- ☐ Has the patient ever been hospitalized? If yes, please explain: ______________________
- ☐ Is the patient taking any medication? If yes, please list: ______________________

Date ______

Confidential Patient Information

Patient's Name ______ (Last) ______ (First) ______ (Middle)

Address: ______ (Street) ______ (City) ______ (State) ______ (Zip)

Home Phone ______ Birthdate ______ Social Security # ______

If patient is a minor, give parent's or guardian's name ______

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

Referral's address ______

Confidential Responsible Party Information

Name ______ (Last) ______ (First) ______ (Middle) Marital Status ______

Residence ______ (Street) ______ (City) ______ (State) ______ (Zip) ☐ Own ☐ Rent

Mailing Address ______ (Street) ______ (City) ______ (State) ______ (Zip)

How long at this address ______ Home Phone ______ Work/Cell Phone ______

Previous Address (if less than 3 yrs.) ______ (Street) ______ (City) ______ (State) ______ (Zip)

Social Security # ______ Birthdate ______ Relationship to Patient ______

Employer ______ Occupation ______ No. Years Employed ______

Spouse's Name ______ (last) ______ (first) ______ (middle) Relationship to Patient ______

Employer ______ Occupation ______ No. Years Employed ______

Social Security # ______ Birthdate ______ Work/Cell Phone ______

E-mail Address ______

Dental Insurance Information

Policy Holder's Name ______ I.D./ Soc. Sec. # ______

Insurance Company ______ Group No. ______ Union Local No. ______

Insurance Co. Address ______ Insurance Co. Phone ______

Policy Holder's Employer ______

Do you have dual coverage? ______ ○ No ○ Yes If yes: ______

Policy Holder's Name ______ I.D./ Soc. Sec. # ______

Insurance Company ______ Group No. ______ Union Local No. ______

Insurance Co. Address ______ Insurance Co. Phone ______

Policy Holder's Employer ______

****Authorization Assignment of Benefits**** ______

Emergency Information

Name of nearest relative not living with you ______

Complete Address ______

Phone ______ Relationship ______

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent signature if minor - please use your mouse or touchpad with your computer, or your finger or stylus on a mobile device)

______

Signature1

(Also an authorization for assignment of insurance benefits.)

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 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 takes effect 5/1/03, and is 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 is 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 t the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this acknowledgement. *

I, ______________________________ have received a copy of the Notice of Privacy Practices for Gorman and Bunch Orthodontics. ,

(Please print parent/guardian's name)

____

Print patient's name

____

Signature2

Signature / Parent signature if patient is a minor

06/01/2016

____

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

____

____