



Patient Information

Date: _____

Patient's Name: _____ Sex: _____ DOB: _____ Age: _____

Name they wish to be called: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Resides with: _____ Relationship to Patient: _____

Person responsible for the account: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

SS#: _____ Insurance Carrier: _____ Date of Birth: _____

Name of Nearby Relative of Patient: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Please answer the following if patient is 18 years old or younger.

Father's Name: _____ SS#: _____

Employer: _____ Work Phone: _____

Mother's Name: _____ SS#: _____

Employer: _____ Work Phone: _____

Patient's School: _____ Hobbies: _____

Other Children in Family: Y / N Were they patients here? Y / N When: _____ Their Ages: _____

Do you realize most Orthodontic appointments are during school hours? _____

How did you hear about us: Dentist Referral _____ Insurance Company _____

Friend Referral _____ Drive by Phone Book Other: _____

Patient's Dentist: _____ Date of Last Check-Up: _____ Any X-rays: _____

Address: _____ City: _____ State: _____ Zip: _____

Chief complaint or reason for seeking orthodontics: _____

Have you ever had any previous orthodontic treatment or been examined by another Orthodontist? Y / N

Describe: _____ Dr. Name: _____ When: _____

Does anyone in the family (other than patient) have any of the following:

crowded teeth spaced teeth protruding teeth Other: _____

Does the patient have any feelings about the appearance of His/Her Teeth? _____

Is the patient interested in having orthodontic appliances? Y / N

Dental History:

Do your teeth hurt? Y / N If yes, Upper Right Upper Left Lower Right Lower Left

Have you ever had treatment for a gum disease? Y / N Please Describe: _____

Have there been any injuries to your mouth or teeth? Y / N Describe: _____

Have you ever had any injury to the head or neck area? Y / N Describe: _____

Have you ever had any surgery in the head or neck area? Y / N Describe: _____

Do you clench or grind your teeth? Y / N If yes, when sleeping under stress other _____

Do your jaw muscles ever feel tired? Y / N If yes, when: _____

Does it hurt to chew? Y / N If yes, where does it hurt? _____

Do you hear clicking, popping or grinding sounds in your jaw joint? Y / N If yes, describe: _____

Have your jaws ever "locked" open wide or closed? Y / N If yes, describe: _____

Do you have pain in your jaw joint? Y / N If yes, describe: _____

Did the patient have a thumb or finger habit? Y / N At what age did he/she quit? _____

Medical History:

Name of Physician: _____ Date of last checkup: _____

Have you had or do you have any of the following:

	Yes	No		Yes	No
Rheumatic Fever	_____	_____	Swollen Glands	_____	_____
Heart Murmur	_____	_____	Allergies (Drug & Other)	_____	_____
High Blood Pressure	_____	_____	List: _____	_____	_____
Heart Attack or Stroke	_____	_____	Asthma	_____	_____
Blood Vessel Disease	_____	_____	Arthritis (any type)	_____	_____
Persistent Headaches	_____	_____	Cancer	_____	_____
Neck Pains	_____	_____	Epilepsy	_____	_____
Nerve or Brain Disease	_____	_____	Tonsilectomy	_____	_____
Migraine	_____	_____	Head or Face Injury	_____	_____
Cold Sores	_____	_____	Psychological Problems	_____	_____
Diabetes	_____	_____	Bleeding Problem	_____	_____
Hepatitis	_____	_____	TB or Lung Problems	_____	_____
AIDS or HIV Positive	_____	_____	Unintentional Weight Loss	_____	_____
Sinus Infection	_____	_____	Current Illness: _____	_____	_____
	_____	_____	Recurrent Illnesses: _____	_____	_____

Comments: _____

Please list any other significant information about your medical history: _____

Are you currently under a physician's care? Y / N If yes, reason: _____

What medications are you currently taking? _____

Signature: _____ Relationship to Patient: _____ Date: _____

{RUSSELL ORTHODONTICS}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

{Please Print Name}

{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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

{RUSSELL ORTHODONTICS}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **J. Russell**

Telephone: **317-576-9400**

Fax: **317-576-9450**

E-mail: **info@russellortho.com**

Address: **13752 Lakeridge Drive Fishers, In 46037**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

{RUSSELL ORTHODONTICS}

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 (MM/DD/YR), and 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.

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, 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. 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 will charge you \$0.05 for each page, \$16.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that 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 14, 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.

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

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or 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 to 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 also may 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 upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Jennifer A. Russell**

Telephone: **317-576-9400**

Fax: **317-576-9450**

E-mail: info@russellortho.com

Address: **13752 Lakeridge Drive**

Fishers, IN 46037

RUSSELL ORTHODONTICS

RELEASE AND ASSIGNMENT

PRIMARY INSURANCE

SECONDARY INSURANCE

Patient Name: _____

Primary Insured Name: _____

Employer: _____

Insured's SS#: _____

Insured's Date of Birth: _____

Dental Ins. Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Effective Date: _____

Insured's Name: _____

Employer: _____

Insured's SS#: _____

Insured's Date of Birth: _____

Dental Ins. Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Effective Date: _____

I hereby authorize the release of any information including diagnosis of treatment or examinations rendered, to my insurance company or companies. I hereby authorize payment to the above named dentist of the insurance benefits otherwise payable to me.

***Failure to fully complete Release and Assignment could result in delay or non-payment of claims.**

SIGNED _____

(Primary Insured)

SIGNED _____

(Primary Insured)

DATE: _____

DATE: _____