Minor Patient Information Sheet

Date_____Patient's Name_____Sex_____

Date Of Birth_____Age_____Nickname_____

Home Phone_____CellPhone_____Email_____

Address_____

School_____Grade_____

Patient's Dentist_____Physican_____

Mother's Name_____Employed By_____

Father's Name_____ Employed By_____

Marital Status___Married___Divorced___Widowed___Single

Name of person responsible for account_____

Address if different from above_____

Do you have Orthodontic Insurance___Yes___No

Name of Insurance Company_____Phone # of Company_____

Name of Insured_____SSN_____DOB_____

Member ID #_____Group Policy #_____

*Mountain Orthodontics Is Out Network for ALL Insurances. Patient is responsible for knowledge of benefits and if predetermination is required_____ (initial)

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

MEDICAL HISTORY:

Is patient in good health?___Yes___No Does patient have any history of major illness?_____Yes_____No

Has patient been under care of a physician for illness:_____Yes_____No

If yes, please list_____

Check any of the following for which patient has been treated:

___Diabetes	___Tuberculosis	___Endocrine Problems	___Nervous Disorders
___Pneumonia	___Anemia	___Prolonged Bleeding	___Liver Involvement
___Heart Trouble	___Epilepsy	___Fainting or Dizziness	___HIV/AIDS
___Rheumatic Fever	___Asthma	___Bone Disorders	___Cancer

Does patient have a tendency to___Sore Throats___Colds___Ear Infections

Have tonsils and/or adenoids been removed___Yes___No

List any medication and supplements being taken_____

_____

List any allergies or drug sensitivities_____

Has the patient reached puberty?___Yes:___No Girls: Started menstruation?___Yes___No

Height_____Weight_____ Boys: Has voice changed?___Yes___No

Any injuries to face, mouth or teeth?___Yes___No

Has patient ever sucked a thumb or fingers?___Yes___No Until what age?___

Is patient a mouth breather?___Yes___No While asleep, awake or both:_____

Missing or extra permanent teeth?___Yes___No

Has an orthodontist been consulted previously?___Yes___No

Reason for appointment?_____

IMPORTANT INFORMATION YOU NEED TO KNOW REGARDING ORTHODONTIC BENEFITS ON YOUR DENTAL POLICY

-Mountain Orthodontics is pleased to file dental insurance as a courtesy for our patients. However, this does not mean that our office is solely responsible to guarantee that your planned benefits are received. In some cases, it may be helpful or necessary for you to contact your insurance company to assist.

-Mountain Orthodontics is an OUT OF NETWORK provider for ALL insurance companies. It is your responsibility, as the subscriber, to know your benefits and any benefit differences for IN or OUT OF NETWORK providers. Often, orthodontic benefits are the same regardless of network status. This is not always the case, and sometimes the differences are significant.

-Please be aware that your policy may:

- -REQUIRE a predetermination BEFORE treatment begins
- -Have a WAITING PERIOD for orthodontic treatment
- -Have an AGE LIMIT for dependents and may not cover adult treatment
- -Have a LIFETIME MAXIMUM for benefit coverage

-If your coverage changes or is terminated for ANY REASON, it is your responsibility to contact Mountain Orthodontics and provide any new insurance information so that we can file your claims in a timely manner.

-Please be aware that some insurance policies DO NOT cover "work in progress" meaning they will not pay on orthodontic treatment that began prior to the effective date of the current coverage.

-Please give attention to all mail you receive from your insurance company. **Some policies issue payments to the subscriber [policy holder] instead of the Provider of Service [Mountain Orthodontics],** even when it has been requested that payments to be sent directly to Mountain Orthodontics. This has caused insurance checks to go unnoticed and un-cashed.

-Most insurance companies issue benefits on a periodic basis, and not in a lump sum. Policies vary, but most policies issue payments on a monthly, quarterly, semiannual, or annual basis. For this reason, the TOTAL EXPECTED benefit may not be received before the end of treatment.

-Please be aware that you are responsible of any outstanding balance at Mountain Orthodontics that is not paid by your insurance company, no matter the reason.

I have read and understand my responsibilities with regard to my insurance coverage.

_____

Patient/Guardian Date

Patient Name:_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements officially began on April 14, 2003. While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review in the reception area.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do no include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is available from the U.S. Department of Health and Human Services. You can find them online at

This summarizes our policy here at Mountain Orthodontics

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, EOB's, etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records may be left, at least temporarily, in administrative areas such as the front office, doctor's desk, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information._____

We send reminders to our patients. We do this by one or more of the following: e-mail, texting, calling, and sending postcards. We try to make every effort to remind you of your appointment and any treatment that you may need. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. We also may send out newsletters or special promotions that we are offering._____

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which includes submitting PHI to receive payment for services provided._____

You give us permission to remind you take pre-medication prior to appointments, if applicable._____

You give us permission to call in any prescriptions you may need and share PHI with the pharmacist._____

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA._____

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties._____

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint._____

Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services without your permission._____

We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice._____

By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future updates to this policy.

SIGNATURE._____