ANDREWS ORTHODONTICS

990 Laurel Street, Suite A
San Carlos, CA 94070
☎ 650-620-9675
650-620-9681
drsara@andrewssmiles.com
andrewssmiles.com

PATIENT INFORMATION - CHILD

Patient Name _____ Age _____ Date of Birth_____

Email _____Main Phone_____

Home Address, City, State, Zip Code _____

General Dentist's Name _____ and Phone_____

How did you hear about our office?_____

What is your main concern regarding your teeth and jaws?_____

MEDICAL HISTORY

Yes _ No _ Have the tonsils and/or adenoids been removed? If so, at what age? _____

Yes _ No _ Frequent colds or ear infections? Please describe_____

Yes _ No _ History of major illness? Please describe _____

Yes _ No _ Any drug sensitivities or allergies? Please describe_____

Yes _ No _ Taking any medication now? Please list _____

Yes _ No _ Under medical care now? Please describe _____

Yes _ No _ Have you been vaccinated and tested for immunity to Hepatitis B (HBV)? Date _____

Yes _ No _ Have you in the past or are you currently undergoing Bisphosphonate therapy? _____

Check any of the following for which you have been treated:

__Diabetes	__ Asthma	__ Prolonged bleeding
__Arthritis	__ Epilepsy	__ Nervous disorders
__Tonsillitis	__ Hepatitis	__ Rheumatic fever
__Brain injury	__ Tuberculosis	__ Heart condition
__Cancer	__ AIDS or HIV	__ Other _____

DENTAL HISTORY

Yes _ No _ Have there been any severe injuries to the face? Please describe_____

Yes _ No _ Are you aware of any missing permanent teeth? Which ones?
_____

Yes _ No _ Has the patient ever sucked their thumb or fingers? If so, until what age?_____

Yes _ No _ Does the patient breathe predominantly through the mouth?

When did the patient last visit the dentist? _____

Medical history reviewed by Dr. Sara Andrews DDS, MS _____

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PERSONAL HISTORY

School _____ Grade _____

Hobbies or Special Interests?_____

Are there any siblings? Please give names & ages.

_____

Is there any other information we should know? If so, please comment:

_____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status_____
Residence _____
Mailing Address if different _____
Main phone _____ Work Phone _____
Birthdate _____ Relationship to patient _____
Employer_____ Employer Address_____
Spouse/Partner name _____ Relationship to patient_____
Employer _____ Employer Address_____
Birthdate _____ Main Phone_____ Work phone _____
Parent's home address and phone if not living with patient_____

DENTAL INSURANCE INFORMATION

To assist us in determining your financial arrangements, and because your insurance is a contract between you and your insurance company, please call your insurance carrier or benefits officer to verify this information BEFORE your appointment.

PRIMARY INSURANCE INFORMATION

Insured's name _____Insured's Soc Sec or ID#_____Group/Local No. _____
Insurance Company _____ Insurance Co. Address _____
Insurance Co. Phone _____ Insured's relationship to patient _____
Ortho Benefits __No __Yes %_____ Lifetime Maximum Amount_____Eligible now __Yes __No
Effective Date _____Are orthodontic records covered under general dental? __Yes __No
Does insurance carrier require additional claim forms after the initial claim form? __Yes __No
If yes, how often?_____
Do you have dual coverage? __Yes __No If yes, please complete the information for the second insurance carrier below.

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SECONDARY INSURANCE INFORMATION

Insured's name _____Insured's Soc Sec or ID#_____Group/Local No. _____
Insurance Company _____ Insurance Co. Address _____
Insurance Co. Phone _____ Insured's relationship to patient _____
Ortho Benefits __No __Yes %_____ Lifetime Maximum Amount_____Eligible now __Yes __No
Effective Date _____Are orthodontic records covered under general dental? __Yes __No
Does insurance carrier require additional claim forms after the initial claim form? __Yes __No
If yes, how often?_____

The information filled out in this packet is accurate to the best of my ability.

Parent/ Guardian Signature _____ Date _____

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PATIENT INSURANCE REGISTRATION FORM

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We work with hundreds of different insurance companies that administer insurance benefits for different employers. Each employer pays an insurance premium for specific orthodontic coverage. This premium is determined by the amount of benefit available for orthodontia. Each plan is slightly different depending on how the employer has negotiated benefits with the insurance company. Companies often change insurance companies in an effort to secure better benefits for smaller premiums. W**e encourage you to become familiar with your policy maximums, percentages, exclusions, deductibles and required co-payments.**

Our courtesy service to you includes:

- As a courtesy, our office will check only your orthodontic benefit with your insurance, however **it is still the patient's responsibility to know their own insurance coverage.**
- As a courtesy, our office will submit your initial orthodontic treatment claim to your insurance.

Our expectations of you as the patient or parent/guardian:

- Payment of fees not covered by your insurance plan.
- **Insurance companies pay their portion due in payments over the patient's treatment time. If you cancel your insurance after treatment has started your insurance will not pay what is remaining. Anything remaining due from the insurance is the patient's responsibility.**
- If there are **any** changes to your insurance, **it is the patient's responsibility to inform our office of these changes.**
- Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
- Taking responsibility for payment if the insurance company does not pay our office.

By signing below, I understand all the above statements. I hereby authorize Dr. Sara Andrews to release to my insurance company, information acquired in the course of my orthodontic care. I hereby authorize benefits to be paid directly to Dr. Sara Andrews. I understand I am responsible for any unpaid balance due from my insurance.

_____ _____

Patient Name **Date**

_____

Patient's Signature or if patient is under the age of 18, Parent/ Legal Guardian's Signature

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Patient Authorization for Communication via Email

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

☐ *I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.*

☐ *I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.*

Print Name:_____

Signature: _____ Date:_____

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Notice of Privacy Practices

This Notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect 9/6/16 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 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. For more information about our privacy practices or additional copies of this Notice, please contact us.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment:
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment:
We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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.

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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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email:
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

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Change of Ownership:
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law:
We may use or disclose your health information when we are required to do so by law.

Public Health:
We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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 official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:
We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting:
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 of how payments will be handled under the alternative means or location you request.

Breach Notification:
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

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Research:
Your health information may be disclosed to researchers for research purposes. In this situation written authorization is not required as approved by an Institutional Review Board or privacy board.

Questions and Complaints:
If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Dr. Sara Andrews

Telephone: (650) 620-9675 Fax: (650) 620-9681

E-mail: info@AndrewsSmiles.com

Address: 990 Laurel Street, Suite A
San Carlos, CA 94070

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

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Acknowledgement of Receipt of Notice of Privacy Practices

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

I,_____, have received a copy of the Andrews Orthodontics Notice of Privacy Practices.

_____ [Please Print Name]

_____ [Signature]

_____ [Date]

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

Personal Representative's name _____

Relationship to Patient _____

For Program 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)