



CONFIDENTIAL

Medical Dental History Form for Adult Patients

PATIENT

Date _____

Patient's Last name _____ First name _____ Middle initial _____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____

Birth date _____ Sex: Male Female Social Security # ____-____-____

Marital Status Single Married Separated Divorced Widowed

Home address _____ City, State, Zip code _____

Home phone (____) _____ - _____ Cell phone (____) _____ - _____ Work phone (____) _____ - _____

E-mail address(es) _____

Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relatives name(s) _____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____

Address (if different than patient address) _____

Home phone (____) _____ - _____ Cell phone (____) _____ - _____ Work phone (____) _____ - _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe _____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain.

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different from page 1) _____ City, State, Zip _____

Home phone (____) _____ - _____ Cell phone (____) _____ - _____ E-mail address(es) _____

Social Security # ____ - ____ - ____ Employer: _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # ____ - ____ - ____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? Yes No Don't know

Secondary policy holder's full name _____ Birthdate _____

Social Security # ____ - ____ - ____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? Yes No Don't know

MEDICAL INSURANCE

Policy holder's full name _____

Insurance company _____

Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, or major injuries?
- yes no dk/u Any injuries to face, head, neck?
- yes no dk/u Arthritis or joint problems?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Diabetes or low sugar?
- yes no dk/u Kidney problems?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Stomach ulcer, hyperacidity, acid reflux?
- yes no dk/u Immune system problems?
- yes no dk/u History of osteoporosis?
- yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or other liver problem?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Seizures, fainting spells, neurologic problem?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u Vision, hearing, or speech problems?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u High or low blood pressure?
- yes no dk/u Excessive bleeding or bruising, anemia?
- yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
- yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
- yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
- yes no dk/u Skin disorder (other than common acne)?
- yes no dk/u Do you eat a well-balanced diet?
- yes no dk/u Frequent headaches or migraines?
- yes no dk/u Frequent ear infections, colds, throat infections?
- yes no dk/u Asthma, sinus problems, hayfever?
- yes no dk/u Tonsil r adenoid condition?
- yes no dk/u Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin
- yes no dk/u Other antibiotics
- yes no dk/u Metals (jewelry, clothing snaps)
- yes no dk/u Acrylics
- yes no dk/u Plant pollens
- yes no dk/u Animals
- yes no dk/u Foods

yes no dk/u Other substances _____

DENTAL HISTORY

Now or in the past, have you had:

- yes no dk/u Permanent or extra (supernumerary) teeth removed?
- yes no dk/u Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Chipped or injured primary or permanent teeth?
- yes no dk/u Any sensitive or sore teeth?
- yes no dk/u Bleeding gums, bad taste or mouth odor?
- yes no dk/u Jaw fractures, cysts, infections?
- yes no dk/u Any teeth treated with root canals or pulpotomies?
- yes no dk/u "Gum boils," frequent canker sores or cold sores?
- yes no dk/u History of speech problems or speech therapy?
- yes no dk/u Difficulty breathing through nose?
- yes no dk/u Food impaction between the teeth?
- yes no dk/u Mouth breathing habit or snoring at night?
- yes no dk/u History of speech problems?
- yes no dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
- yes no dk/u Teeth causing irritation to lip, cheek or gums?
- yes no dk/u Abnormal swallowing (tongue thrust)?
- yes no dk/u Tooth grinding or clenching?
- yes no dk/ u Clicking, locking in jaw joints?
- yes no dk/u Soreness in jaw muscles or face muscles?
- yes no dk/u Ringing in ears, difficulty in chewing or opening jaw?
- yes no dk/u Have you ever been treated for "TMJ" or "TMD" problems?
- yes no dk/u Any broken or missing fillings?
- yes no dk/u Any serious trouble associate with previous dental treatment?
- yes no dk/ u Have you ever been diagnosed with gum disease or pyorrhea?
- yes no dk/u Have you ever had an orthodontic consultation or treatment before now?

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____

How often do you floss? _____

Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____



Viney P. Saini, DDS, MS, LLC

PRIVACY POLICY

I. INTRODUCTION

Recently, the United States Department of Health and Human Services ("HHS") issued comprehensive regulations relating to the privacy of patient records. It is the intent of this office to comply with each of these new rules, and this policy is designed to provide a framework to accomplish this goal.

These rules apply to this office because, among other things, we transmit patient records electronically. However, the rules apply to *all* "protected patient information," whether in electronic or paper form, or whether disclosed orally. For purposes of this Privacy Policy, "protected patient information" includes any individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data. Employment records are not included within the definition (and thus not subject to the privacy rule) unless they are used in connection with the provision of employment.

II. PRIVACY OFFICIAL

Dr. Saini shall be this office's "privacy official." As such, he shall be responsible for implementing this Privacy Policy, as well as developing any future amendments or revisions to this Policy.

III. CONTACT PERSON

Dr. Saini shall be designated as this office's "contact person." He shall therefore be responsible for receiving any complaints or inquiries about patient privacy matters, and responding to such complaints or inquiries.

The Contact Person shall document all complaints or inquiries received.

If any patient or other person desires to make a complaint relating to patient privacy, the Contact Person shall instruct him or her to submit the complaint in writing. The Contact Person shall then

investigate the complaint or inquiry, determine a resolution in conjunction with Dr. Saini, and respond to the complainant or inquirer as to the results of the investigation and resolution.

If the inquiry is a complaint, the person shall be advised of his/her right to file a complaint with HHS and notified that the complaint must be filed within 180 days of the date of the alleged violation.

IV. PRIVACY TRAINING

This office will routinely undertake privacy training for all staff. The training will occur on an annual basis for all existing staff, unless otherwise changed to a more frequent basis. In addition, all new staff shall participate in privacy training immediately upon their commencement of employment with this office. A written record of this training will be maintained by the Privacy Official.

V. USE AND DISCLOSURE OF PROTECTED PATIENT INFORMATION

A. GENERALLY

No protected patient information shall be used or disclosed in any manner other than in conformity with this Policy. Staff should always be mindful of the need to maintain confidentiality of patients' records and protected health information. Thus, for example, in certain instances it may be appropriate to lower voices or request waiting patients stand a few feet away from patients with whom you are discussing treatment aspects, scheduling appointments, etc.

B. NOTICE AS TO USE AND DISCLOSURE OF PATIENT INFORMATION

The form Notice attached to this Policy shall be given to all patients *at their first appointment*. A copy of the signed and dated Notice must be maintained in each patient's file.

The notice may be amended upon approval of Dr. Saini. If the Notice is amended, it must be amended promptly and distributed to all patients who have been given the earlier version(s). No material change to the Notice will be implemented prior to the effective date shown on the revised notice.

C. CONSENT TO USE AND DISCLOSE PATIENT INFORMATION

The form Consent attached to this Policy is optional and may, at the option of Dr. Saini, be presented to all patients with the notice. If it is used, it should be presented at their first appointment and prior to the disclosure of any of the patient's protected health information, and must be signed and dated by the patient. A copy of the signed and dated Consent shall be kept in the patient's file.

This form relates to the use or disclosure of any protected patient information in connection with treatment, payment or "health care operations." (Health care operations include performance reviews, training, obtaining professional liability insurance, certification, accreditation and licensing.)

The Notice and Consent may not be combined on the same form.

D. AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

If Dr. Saini ever determines that protected patient information will be used or disclosed for any purpose other than in connection with treatment, payment or health care operations (defined above), then the patient must sign the form Authorization attached to this Policy. For example, this form would be appropriate where the patient's information will be used to determine whether to hire the patient, making a disclosure of the information to a financial institution, marketing, etc.

Special rules apply (and additional items must be included in the form) where Dr. Saini intends to use the protected health information for his own purposes, additional items are requested by Dr. Saini in connection with disclosure by other third parties, or where the use or disclosure relates to research that includes the patient's treatment.

Patient will not be refused treatment on the basis of his/her refusal to sign the Authorization form, unless the treatment will be used for research, in which case treatment may be refused at the option of Dr. Saini. A patient may revoke the Authorization in writing at any time. In general, the form Authorization should be reviewed by legal counsel prior to signature by the patient.

E. "MINIMUM NECESSARY" USE AND DISCLOSURE OF PATIENT INFORMATION FOR NON-TREATMENT PURPOSES

Wide latitude is given as to the use or disclosure of patient information for purposes of treatment. Thus, any information that Dr. Saini deems appropriate will be used or disclosed.

However, if the use or disclosure of protected patient information occurs for any other reason (i.e., for payment, reimbursement or health care operations, etc.), the information used, disclosed or requested must be limited to the minimum degree necessary to accomplish the purpose for which the use, disclosure or request is made. (Note that this restriction does not apply to uses or disclosures of the information to the patient to whom the information relates.)

F. DISCLOSURES TO SERVICE PROVIDERS

Any disclosure to service providers by this office (i.e., labs, collection agencies, attorneys, accountants, etc.) may only occur after certain safeguards are in place. Namely, there must be a written agreement substantially in the form attached to this Policy prior to the release of any protected patient information. Because there are special rules in the privacy regulations relating to vendors and unique state laws, the attached form should be reviewed by legal counsel prior to signature.

VI. SPECIFIC PATIENT REQUESTS

A. FOR RESTRICTIONS ON USE AND DISCLOSURE

Patients may request restrictions on the use and disclosure of their protected health information. However, we are not obligated to honor these requests. But if we elect to honor the request, we must adhere to it. Any denial must be in writing.

B. FOR COMMUNICATION OF THEIR INFORMATION

Patients have the right to request confidential communication of their protected health

information. For example, they may request that the information be communicated by alternative means (i.e., sending correspondence to their office rather than to their home). If such a request is made, it should be in writing and we will abide by that request as long as it is reasonable. We are not allowed to inquire as to the reason(s) for the request.

C. FOR INSPECTION AND COPIES OF THEIR RECORDS

Consistent with applicable ethics rules of the American Association of Orthodontists and the new privacy rules, we will provide patient records to them or their designee at any time. However, special permission from Dr. Saini must be obtained prior to releasing the information if the information is compiled in anticipation of, or for use in, litigation or administrative (i.e., dental board) proceedings. (The new privacy rules do not require that the information be provided to the patient in those instances.) Any denial must be in writing. We have 30 days after receiving a request for access or copies from a patient within which to provide the access or information, unless the data is maintained off-site, in which case we have 60 days from the date of the request. A 30-day extension may be obtained if, within the initial 30-day period, we provide written notice to the patient of the reasons for the delay and give a date on which we will provide a response.

D. TO AMEND OR MODIFY THEIR HEALTH INFORMATION

From time to time, patients may request that their protected health information be modified. Generally, we will honor their requests. However, such requests will not be honored if the information is accurate and complete, or if we did not create the information.

If we honor the request, we must obtain a list of persons or entities that the patient wants us to inform of the amendment from the patient, along with the patient's authorization to inform them. We must then undertake reasonable efforts to notify those persons or entities of the amendment. If we deny the request, the denial must be in writing and advise the patient of (1) the reasons for the denial, (2) their right to submit a "written disagreement," (3) his/her right to ask that the request to amend and our denial be included with any future disclosure of the subject information if not "written disagreement" is submitted, and (4) his/her right to file a complaint with the HHS Secretary.

We must respond to any request to amend health information within 60 days of receiving the request. An additional 30 days is allowed if, within the original 60-day period, we notify the patient of the reason(s) for the delay and provide a date on which we will provide a response.

E. FOR AN ACCOUNTING OF DISCLOSURES

If requested and unless an exception exists, we will provide patients with a written accounting of all disclosures of their protected health information that we have made for the period requested, but not to exceed six years from the date of the request.

Unless decided otherwise by Dr.Saini we will not provide disclosures relating to the following:

1. Treatment of the patient, including disclosures made to other treatment providers (i.e., their general dentist, periodontist, etc.);
2. Payment on behalf of the patient;
3. Health Care Operations (i.e., information disclosed in connection with performance reviews, training, certification, accreditation or licensing);
4. Disclosures made to the patient or those involved in the care of the patient;
5. Incidental disclosures (i.e., from sign-up sheets, overheard conversations, etc.);

6. Any disclosures that occurred pursuant to an Authorization signed by the patient; or
7. Any disclosures that occurred prior to April 14, 2003.

We must respond to a patient's request for an accounting of disclosures within 60 days of the request.

We can obtain an additional 30 days to respond by, within the initial 60-day period, providing the patient with written notice of the reason(s) for the delay and giving a date on which a response will be provided. Patients are entitled to one free accounting within a 12-month period. Any further requests for an accounting of disclosures may involve a reasonable fee, which will be determined by Dr. Saini on a case-by-case basis.

VII. VIOLATION OF PRIVACY POLICY

Any violation of this Privacy Policy shall be grounds for discipline, including termination. Compliance with this Policy is required in addition to all other office personnel policies, if any.



Viney P. Saini, DDS, MS, LLC

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice. You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's Signature _____

Print Name _____ Date _____