patient's name: ____ **dob:** ____________________

dentist's name: ____

medical/dental history

	yes	no
is your child currently under any medical treatment? **if yes, please explain:** __________________________________		
is your child currently taking any medication? **if yes, please list:** _____________________________________		
does your child have allergies? (nickel, latex, ibuprofen, penicillin, novocaine, etc.) **if yes, please explain:** ___________________________________		
does your child have any condition that requires premedication prior to dental treatment?		
has your child ever been diagnosed with any bone diseases such as Osteopenia, Osteoporosis or Paget's Disease?		
has your child ever taken a bone building or strengthening medication to reduce bone loss such as **Fosamax**?		
females: is there any chance of pregnancy?		
does your child have pain, clicking, and/or popping noises in the jaw?		
are you aware of either clenching or grinding of teeth?		
does your child have habits such as nail biting, finger or thumb sucking, lip or cheek biting?		
does your child have speech problems, or in speech therapy?		
has your child had any history of previous orthodontic treatment?		
have there been any injuries to the teeth?		
have we treated any other family members? **if yes, who:** ________________________________		

pediatric sleep questionnaire

while sleeping does your child...	yes	no	don't know	**does your child...**	yes	no	don't know
snore loudly?				have difficulty paying attention?			
have heavy or loud breathing?				have problems with irrationality?			
have trouble breathing or struggle to breathe?				have poor school performance?			
occasionally wet the bed?				have any history of nasal obstruction?			
does your child…				have headaches?			
breathe through their mouth at night?				is your child overweight?			
tend to breathe through their mouth during the day?				have any previous diagnosis of obstructive sleep apnea?			
wake up feeling un-refreshed in the morning?				have seasonal allergies?			
have a problem with sleepiness during the day?							

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever any change to my child's medical history, or a medications change, I will inform the doctor at the next appointment without fail.

Responsible Party's Signature: ________________________________ **Date:** ____________

Doctor's Signature: ___________________________________ **Date:** ______________

insurance questionnaire

Patient: ______________________________

Date of Birth: ______________________________

PRIMARY CARRIER INFORMATION

Subscriber: ______________________________

Date of Birth: ______________________________

Insurance Company: ______________________________

SS# or ID# on Card: ______________________________

Employer Name & Group #: ______________________________

Phone # for Providers: ______________________________

OFFICE USE ONLY

Benefit: ____________	Used: ____________	Verified by: ____________
Covered at: ____________%	COB: ____________	Date: ____________
Waiting period: ____________	Pays: ____________	AGE: ____________

SECONDARY CARRIER INFORMATION

Subscriber: ______________________________

Date of Birth: ______________________________

Insurance Company: ______________________________

SS# or ID# on Card: ______________________________

Employer Name & Group #: ______________________________

Phone # for Providers: ______________________________

OFFICE USE ONLY

Benefit: ____________	Used: ____________	Verified by: ____________
Covered at: ____________%	COB: ____________	Date: ____________
Waiting period: ____________	Pays: ____________	AGE: ____________

primary consent

PRIVACY CONSENT

This form is 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 review, certification, accreditation and licensure). Treatment plans, insurance and financial correspondence may be sent via email/text. In certain instances, a 'virtual' online conference may be needed or requested using various online applications such as Zoom or Webex.

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.

____

Parents/Patient Signature

____

Print Parent's Name

____

Print Patient's Name

____

Date

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- 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 date) may be used or disclosed by us in one or more of the following respects:
- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling etc.
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

Contact Officer: Fiona Ashley/Dr. Brian L. Ting
978-692-5799 Fax: 978-692-5792, 73 Littleton Road, Westford, MA 01886