CHAMPION
Orthodontics

A Professional Dental Corporation

4101 Tully Road • Suite 401
Modesto, California 95356

New Patient Information Sheet

1 About You

Today's Date:_____

Email Address:_____

Name:_____
LAST FIRST MI MR MRS MS DR

I prefer to be called:_____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age:_____ SS #:_____

What sex were you assigned on your birth certificate? ❑ Male ❑ Female

What is your current gender identification? ❑ Male ❑ Female ❑ Other

What are your preferred pronouns? _____

Home Address:_____
APT / CONDO #

_____
CITY STATE ZIP

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Hm #: (____)_____Pager / Other #:_____

Wk #: (____)_____Ext.:_____DL#:_____

Employer:_____

Employer Address:_____

How long there?_____ Occupation:_____

Where & when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

General Dentist:_____

Last Visit Date:_____

2 Spouse Information

His / Her Name:_____
LAST FIRST MI MR MRS MS DR

Employer:_____

Wk #: (____)_____Ext.:_____SS #:_____

Birthdate: ____/____/____

Person Responsible for Account:_____

Wk #: (____)_____Ext.:____Hm #: (____)_____

Billing Address:_____

Relation:_____ SS #:_____

Employer:_____ DL #:_____

3 Orthodontic Insurance

Primary

Orthodontic Coverage ☐ Yes ☐ No Dental Coverage ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #(____)_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer:_____

Secondary

Orthodontic Coverage ☐ Yes ☐ No Dental Coverage ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #(____)_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer:_____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name:_____

Relation:_____

Wk #: (____)_____ Hm #: (____)_____

4 Medical Information

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:_____

Phone #: (____)_____

Date of last visit:_____

CONTINUED ON BACK

4 Medical History *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐Yes ☐ No

Please explain:_____

Are you taking any prescription / over-the counter drugs? ☐Yes ☐ No

Please list each one:_____

For Women:

Are you using a prescribed method of birth control ☐Yes ☐ No

Are you pregnant? ☐Yes ☐ No Week #:_____

Are you nursing? ☐Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y N	Abnormal Bleeding	Y N	Hemophilia
Y N	Anemia	Y N	Hepatitis
Y N	Artificial Bones / Joints / Valves	Y N	High / Low Blood Pressure
Y N	Asthma / Arthritis	Y N	HIV/ AIDS
Y N	Blood Transfusion	Y N	Hospitalized for Any Reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Radiation Treatment
Y N	Drug / Alcohol Abuse	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema	Y N	Severe / Frequent Headaches
Y N	Epilepsy / Seizures / Fainting	Y N	Shingles
Y N	Fever Blisters / Herpes	Y N	Sickle Cell Disease / Traits
Y N	Glaucoma	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers / Colitis
Y N	Heart Surgery / Pacemaker	Y N	Venereal Disease

Please List any serious medical condition(s) that you ever had:

_____

Are you allergic to any of the following

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metals / Plastics	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs / materials that you are allergic to:

_____

5 Dental History

What are the main concerns that you would like orthodontic treatment to correct?

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐Yes ☐ No

If Yes Please Explain:_____

Have you ever had a serious / difficult problem associated with any previous dental work? ☐Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐Yes ☐ No Gums ever bleed? ☐Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems?_____

Do you generally breath through your mouth? ☐Yes ☐ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐Yes ☐ No

Have you ever taken Phen-Fen? ☐Yes ☐ No

Do you use or smoke tobacco in any form? ☐Yes ☐ No

6

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature:_____

Date

! Thank you for filling out this form completely

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use one or more credit reporting services.

Signature:_____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office

Signature:_____

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____ Date:_____

Doctor's Comments:_____

_____

_____

_____

_____

_____

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 as described below. This Notice takes effect on April 14, 2003, and will remain in effect until it is amended or replaced by us.

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, this Notice will be amended to reflect the changes and the new Notice will be 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. Your protected health information (i.e., individually identifiable information, such as names, dates, telephone and fax numbers, e-mail addresses, home addresses, social security numbers and demographic data) may be used or disclosed by us. 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. This disclosure may include spouses, insurance organizations or other businesses (i.e., third party payors, employers with direct reimbursement, administrators of flexible spending accounts, etc.) that may become involved in collecting or obtaining payment of your account.

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.

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 institutions or law enforcement officials 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) and information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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 it is impractical to 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 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. Upon request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

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.

Practice Name: Champion Orthodontics

Telephone: (209) 575-5888

Fax: (209) 575-5898

E-mail: info@championsmiles.com

Address: 4101 Tully Road, Suite 401, Modesto, California 95356

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

I consent to the dental practice using my cell phone number to call/text regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

_____
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) _____

_____
Employee signature Date