CHAMPION
Orthodontics

A Professional Dental Corporation

4101 Tully Road • Suite 401
Modesto, California 95356

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date:_____ Nickname:_____

Child's Name:_____
LAST FIRST M

Email Address:_____ SS#_____

Birthdate:____/____/____ Age:_____

What sex was the patient assigned on their birth certificate? ❑ Male ❑ Female

What is the patient's current gender identification? ❑ Male ❑ Female ❑ Other

What are the patient's preferred pronouns? _____

School:_____ Grade:_____

Hobbies / Sports:_____

Child's Home # ( )_____

Child's Home Address:_____
APT/CONDO #

_____
CITY STATE ZIP

2 Who is Accompanying Your Child Today?

Name:_____ Relation :_____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we thank for referring you: _____

List brothers / sisters with ages:_____

_____

General Dentist: _____

Last Visit Date: _____

Parents Marital Status: ❑ Married ❑ Separated ❑ Widowed
❑ Single ❑ Partnered ❑ Divorced

3 ❑ Mother's Information ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ____/____/____

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

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS#: _____ DL #_____

❑ Father's Information ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ____/____/____

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

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS#: _____ DL #_____

4 Person Responsible For Account

Name:_____ Relation :_____

Address:_____
APT/CONDO #

_____
CITY STATE ZIP

Previous Address: _____
APT/CONDO #

_____
CITY STATE ZIP

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

SS #_____ DL # _____

Employer: _____

Who is responsible for making appointments.

Name: _____

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

5 Primary Orthodontic Insurance

Orthodontic Coverage ❑ Yes ❑ No

Insurance Co Name:_____

Insurance Co. Address: _____

Insurance Co. Phone # ( ) _____

Group 3 (Plan, Local or Policy #):_____

Policy Owner's Name: _____

Relationship to Patient:_____

Policy Owner's Birthdate: ____ / ____ / ____ ID #: _____

Policy Owner's Employer:_____

Employer's Address:_____

Secondary Orthodontic Insurance

Orthodontic Coverage ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # ( ) _____

Group 3 (Plan, Local or Policy #):_____

Policy Owner's Name: _____

Relationship to Patient:_____

Policy Owner's Birthdate: ____ / ____ / ____ ID #: _____

Policy Owner's Employer:_____

Employer's Address:_____

CONTINUED ON BACK

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

_____

_____

Has you child ever taken Phen-Fen? ❑ Yes ❑ No
(Also known as Redux or Pondimin) If yes, when?_____

Has your child ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed on any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Does your child brush his / her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: ( ) _____Date of Last Visit: _____

Is your child currently under the care of a physician? ❑ Yes ❑ No

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

Please describe your child's current physical health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that your child is currently taking: _____

_____

Please list all drugs / things that your child is allergic to: _____

_____

_____

7 Has your child ever had any of the following medical problems?

Y N	Abnormal Bleeding	Y N	Convulsions / Epilepsy
Y N	ADD / ADHD	Y N	Diabetes
Y N	Allergies to any Drugs	Y N	Handicaps / Disabilities
Y N	Allergic to Latex / Metals	Y N	Hearing Impairment
Y N	Allergic to Plastic	Y N	Heart Murmur
Y N	Any Hospital Stays	Y N	Hemophilia
Y N	Any Operations	Y N	Hepatitis
Y N	Artificial Bones / Joints / Valves	Y N	HIV / AIDS
Y N	Asthma	Y N	Kidney / Liver Problems
Y N	Cancer	Y N	Lupus
Y N	Congenital Heart Defect	Y N	Rheumatic / Scarlet Fever
		Y N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

8 Has your child ever experienced any of the following?

Y N	Clenching / Grinding Teeth	Y N	Nursing Bottle Habits
Y N	Lip Sucking / Biting	Y N	Speech Problems
Y N	Mouth Breather	Y N	Thumb / Finger Sucking
Y N	Nail Biting	Y N	Tongue Thrust

Neighbor or Relative not living with you:

Name_____ Phone: ( )_____

Address: _____
APT/CONDO #

_____
CITY STATE ZIP

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I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

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: _____

I authorize the dental staff to perform any necessary dental services my child may need.

_____
Signature of parent or guardian Date

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

Signature: _____

The Parent or Guardian who accompanies the child is responsible for payment.
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