MERIDIAN PARK ORTHODONTICS

Medical & Dental History for Patients Under Age 18

Welcome! Please Tell Us About Your Child

Patient Last Name

Patient First Name M.I.

Prefers to be called

Hobbies & activities

□ Male □ Female

Birth date Age

School Grade

Home address

City State Zip

Home phone

Cell phone

Email address (appointment reminders will be sent to this address)

Parents/Guardians

Who is accompanying the patient today?

Relationship to patient?

Custodial parent(s) name(s)

Patient lives with (check all that apply)
□ mother □ father □ stepmother □ stepfather
□ grandparent(s) □ other

1st Parent Information

Relationship to patient (example: mom, dad)

Parent last name First

□ Mr. □ Mrs. □ Ms. □ Dr. □ Other

Occupation

Email address

Address *(if different)*

Home phone *(if different)*

Cell phone

Work phone

2nd Parent Information

Relationship to patient (example: mom, dad)

Parent last name First

□ Mr. □ Mrs. □ Ms. □ Dr. □ Other

Occupation

Email address

Address *(if different)*

Home phone *(if different)*

Cell phone

Work phone

General Information

What concerns you about your child's teeth? What would you like orthodontic treatment to accomplish?

What concerns your child about their teeth?

How does your child feel about orthodontic treatment?

Who suggested that your child might need orthodontic treatment?

Why did you select our office?

Has your child had previous orthodontic treatment? □ Yes □ No
Please describe:

Have you consulted with another orthodontist? □ Yes □ No

Brother/sister name Age
Had orthodontic treatment? □ Yes □ No If yes, where?

Brother/sister name Age
Had orthodontic treatment? □ Yes □ No If yes, where?

Brother/sister name Age
Had orthodontic treatment? □ Yes □ No If yes, where?

Have any other family members or friends been treated in this office? □ Yes □ No Please name them

 Patient Name_____

Medical History

Now, or in the past, has your child experienced any of the following:

Y N	Birth defects or hereditary problems	Y N	Bone fractures or major injuries	Y N	Any injury to face, head, neck
Y N	Arthritis or joint problems	Y N	Endocrine or thyroid problems	Y N	Diabetes or low blood sugar
Y N	Kidney problems	Y N	Cancer, tumor, radiation or chemotherapy	Y N	Stomach ulcer or acid reflux
Y N	Immune system problems	Y N	Osteoporosis or bone disorders	Y N	AIDs or HIV positive
Y N	Hepatitis, jaundice or other liver problem	Y N	Polio, mononucleosis, tuberculosis, pneumonia	Y N	Seizures, fainting spells, neurologic problem
Y N	Mental illness or depression	Y N	Vision problems	Y N	Hearing problems
Y N	Eating disorders	Y N	High or low blood pressure	Y N	Excessive bleeding or anemia
Y N	Chest pain or shortness of breath	Y N	Heart defects, hear murmur, rheumatic heart disease	Y N	Stroke or heart attack
Y N	Skin disorder (other than acne)	Y N	Frequent headaches or migraines	Y N	Frequent ear or throat infections
Y N	Asthma or sinus problems	Y N	Tonsil or adenoid conditions	Y N	Use of cigarettes or cigars
Y N	Use of smokeless tobacco	Y N	Substance abuse	Y N	Treatment with bisphosphonate medications (Fosamax, Boniva, Actonel, didronel, Aredia, Skelid, or Zometa)
Y N	For female patients (when appropriate), pregnant?	Y N	For girls, Has menstruation started?	Y N	For boys, has voice changed?

Y N Other illness or medical condition_____

Has your child had **allergies** or reactions to any of the following:

Y N	Latex	Y N	Local anesthetics (novocaine, lidocaine, xylocaine)	Y N	Penicillin
Y N	Other antibiotics	Y N	Metals (jewelry, clothing snaps)	Y N	Other substances or medications_____

Please list any **medications** or supplements that your child takes

_____ Taken for _____

_____ Taken for _____

Does your child take antibiotic pre-medication before dental procedures? □ Yes □ No

Dental History

Now or in the past, has your child experienced any of the following:

Y N	Permanent teeth removed or missing	Y N	Sucked thumb or fingers
Y N	Chipped or injured teeth	Y N	Sensitive or sore teeth
Y N	Bleeding gums, bad taste or mouth odor	Y N	Jaw cysts or infections
Y N	Frequent canker sores or cold sores	Y N	Speech problems or speech therapy
Y N	Difficulty breathing though nose or frequent mouth breathing	Y N	Snoring
Y N	Abnormal swallowing (tongue thrust)	Y N	Tooth grinding or clenching
Y N	Clicking or popping of the jaw joint	Y N	Difficulty opening or closing jaw
Y N	Soreness in jaw or facial muscles	Y N	Treatment for TMJ or TMD
Y N	Serious difficulty associated with dental treatment	Y N	Diagnosis or treatment for gum (periodontal) disease

 Patient Name_____

Dentist

Name City

Last seen Reason

Were X-rays taken? □ Yes □ No □ Don't know

Other dentists/dental specialists now being seen

Name City

Reason

Physician

Name City

Phone number

Last seen Reason

Other physicians/health care providers now being seen

Name City

Phone number

Reason

Dental Insurance

Policy holder's full name

Policy holder's birth date

Relationship to patient

Policy holder address and phone *(if not listed above)*

Employer

Ins. Co. Name

Member ID #

Group #

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

Is your child covered by a secondary policy? □ Yes □ No

Financial Responsibility

Who is financially responsible for this account?

If this person was not listed previously, complete below:

Address

Home phone Cell phone

Email

Relationship to patient

Employer

Release and Waiver

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

I authorize Meridian Park Orthodontics to communicate with me electronically through email. I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I have read the health history questions and understand them. I will not hold my orthodontist or any member of his 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 child's medical or dental health.

Parent/Guardian Signature _____ Date _____

ACKNOWLEDGEMENT

OF RECEIPT OF
MERIDIAN PARK ORTHODONTICS NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

Patient Signature:_____ Date: _____

If Personal Representative, description of authority (parent/guardian, etc): _____

Name(s) of individuals(s)
representing:_____

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
__Communication barriers prohibited obtaining the acknowledgement
__An emergency situation prevented us from obtaining acknowledgement
__Other (Please Specify):

MERIDIAN PARK ORTHODONTICS
NOTICE OF PRIVACY PRACTICE

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 PROTECTED HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect September 25, 2014, and will remain in effect until we replace it.

We reserve the right to change our privacy policies 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 protected health information that we maintain, including protected 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.

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 protected health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your protected health information to a dentist, hygienist, or other healthcare provider for treatment purposes.

Payment: We may use and disclose your protected health information to bill for and collect payment for services we provide to you.

Healthcare Operations: We may use and disclose your protected health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare providers, evaluating provider performance, conducting training programs, peer review, accreditation, certification, licensing or credentialing activities.

Authorization: In addition to our use and disclosure of your protected health information for treatment, payment or healthcare operations, you may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You may revoke such authorization at any time by written request, but we cannot take back any uses or disclosures already made with your permission. Unless you give us a written authorization, we cannot use or disclose your protected health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose protected health information about you to your family members or friends if we obtain your verbal authorization to do so or if we give you an opportunity to object and you do not object. We also may disclose protected health information to your family or friends if we can infer from the circumstances, based on our reasonable judgment that you would not object. For example, when you bring your spouse with you when treatment is discussed. We may use our professional judgment to infer that it is in your best interest to allow another person to pick-up filled prescriptions, medical supplies, x-rays or recommend that they take you to your physician or emergency room.

We may use or disclose protected 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 you location, or your general condition. If you are present, then prior to use or disclosure of your protected health information, we will provide you an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose protected health information based on a determination using our professional judgment, disclosing only protected health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: We may use or disclose your protect health information for marketing purposes with your written authorization.

Required by Law: We may use or disclose your protected health information when we are required to do so by federal, state or local law or legal process, for example, subpoena, court order, administrative order, warrant, or summons; and pursuant to worker's compensation laws.

Abuse or Neglect: We may disclose your protected 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 protected health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Government Officials and Law Enforcement: We may disclose to authorized governmental officials protected health information required for lawful investigation, military authorities, the protected health information of Armed Forces personnel, and a correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as postcards, voicemail message, letters, text messages, or Email) or information about oral health care, and related benefits and services.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such a copies, postage, and staff time. If you request an alternative format that we can practicably provide, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 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 in writing that we place additional restrictions on our use or disclosure of you protected 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). We are required to agree to requests that we not disclose protected health information to your health plan with respect to services for which you have paid out of pocket in full.

Alternative Communications: You have the right to request that we communicate with you about your protected 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 protected health information. Your request must be in writing, and it mush explain whey the information should be amended. We may deny your request under certain circumstances

Breach notification: You have the right to receive notice if the security of your unsecured protected health information is breached.

Electronic Notice: If you receive this Notice on our Web site or by Email, you are entitled to receive a paper copy of the Notice upon request.

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 protected health information or in response to a request you make to amend or restrict the use of disclosure of your protected health information or to have us communicate with you by alternative means or at alternative locations, you may submit a complaint 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. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your protected health information. You will not be penalized in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Patient Rights Information And Complaints:

Meridian Park Orthodontics
19255 SW 65th Ave #230
Tualatin, OR 97062
(503) 691-9970