The SmileSpot

FOR CHILDREN: WELCOME TO OUR PRACTICE

1. Tell us About Your Child

Today's Date: _____ DOB: _____

Child's Name:

_____

Last First MI

Nickname: _____ ❑Male ❑Female

School: _____ Grade: _____

Home #: _____Cell #:_____

SS#: _____

Child's Home Address:

_____

_____

City State Zip

2. Who is with the Child Today?

Name: _____

Relationship: _____

Do you have legal custody? ❑YES ❑NO

Who may we thank for referring you? _____

_____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Street: _____

Phone #: _____

Last Visit: _____

Parent's Marital Status: (circle one) ❑Married

❑Single ❑Divorced

3. Mother's Information:

Name: _____

Cell #: _____ Home#: _____

Employer: _____

DL#: _____ SS#: _____

Father's Information:

Name: _____

Cell#: _____ Home#: _____

Employer: _____

DL#: _____ SS#: _____

4. Who is Responsible for Payment?

Name: _____

Billing Address: _____

_____

City State Zip

Cell#: _____ Ext: _____

Home#: _____

Employer: _____

DL#: _____ State: _____

SS#: _____

Who is Responsible for Making Appointments?

Name: _____

Cell#: _____ Home#: _____

Email: _____

Preferred method of contact: ❑Email ❑ Text

❑Phone: _____

Primary Dental Insurance

Insurance Name: _____

Ins. Address: _____

Ins. Company Phone #: _____

Group/Policy#: _____

Insured's Name: _____

Relationship to patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: ❑YES ❑NO

Secondary Dental Insurance

Ins. Name: _____

Ins. Address: _____

_____

Ins. Company Phone#: _____

Group/Policy#: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

SS#: _____

Orthodontic Coverage: ❑YES ❑NO

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6. Why did you bring the child to Orthodontist today?

Has the child even had a serious/difficult problem associated with dental work? ❑YES ❑NO
Is the child's water fluoridated? ❑YES ❑NO
Is the child taking fluoridated supplements? ❑YES ❑NO
Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ❑YES ❑NO
Does the child brush teeth daily? ❑YES ❑NO
Floss their teeth daily? ❑YES ❑NO
Child's Physician: _____
Phone#: _____ Last Visit: _____
Is the child currently under the care of a physician? ❑YES ❑NO
Please describe the child's health:
❑Good ❑Fair ❑Poor
Please list all drugs the child is currently taking:
_____
_____
Please list all drugs the child is allergic to: _____
_____
_____

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

❑Y ❑N Heart Murm.	❑Y ❑N Cong. Heart Def
❑Y ❑N Cancer	❑Y ❑N Convulsions
❑Y ❑N Diabetes	❑Y ❑N Abnormal Bleeding
❑Y ❑N Rheum. Fev	❑Y ❑N Hearing Impaired
❑Y ❑N HIV+/AIDS	❑Y ❑N Any Operations
❑Y ❑N Hemophilia	❑Y ❑N Any hospital stays
❑Y ❑N Asthma	❑Y ❑N Kidney/Liver Issues
❑Y ❑N Hepatitis	❑Y ❑N Handicap/Disability
❑Y ❑N Tuberculosis	❑Y ❑N Any drug allergies
❑Y ❑N Prosthesis	❑Y ❑N Scarlet Fever

Please discuss any serious medical problems that the child has had: _____
_____

8. Does the child have any of the following habits?

❑Y ❑N Thumb sucking/Finger sucking
❑Y ❑N Lip sucking/biting
❑Y ❑N Nail biting

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

9. I understand the information I have given is correct to the best of my knowledge, that I will be held in the strictest confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of parent/guardian Date

The parent/guardian who accompanies the child is responsible for payment at the time of services unless prior arrangements have been approved.

OFFICE USE ONLY- OFFICE USE ONLY- OFFICE USE ONLY

I verbally reviewed the medical/ dental information above With the parent/ guardian & patient named herein.

Initials: _____ Date: _____
Doctor's Comments: _____
_____
_____
_____

Medical History Update
1. Date: _____ Signature: _____
Comments: _____
_____
2. Date: _____ Signature: _____
Comments: _____
_____
_____

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 request copies, a fee may apply for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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.
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

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.

Right to notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Service upon request. 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

Privacy Official Name and Contact Information:
Connie Moore (816)-363-2900

This material is educational only and does not constitute legal advice and covers only federal, not state law. Changes in applicable laws or regulations may require revision. Dentist should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S Department of Health and Human Services rules and regulations.

The SmileSpot

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.

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 that are described in this Notice while it is in effect. This Notice takes effect 1/1/2009, and will remain in effect until we replace it. 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, 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

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. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party.

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.

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 persons 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.
Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose your health information for public health activities including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect
- Report reactions to medications or problems with products or devices
- Notify a person who may have been exposed to a disease or condition; or notify the appropriate authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 institution or law enforcement official having lawful custody of the protected health information of an inmate or patient.

Secretary of HHS: We will disclose your information to the Secretary of the U.S Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws when relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Research: We may disclose your PHI to researches when an institutional review board or privacy board with established protocols to ensure the privacy of your information has approved their research.

Judicial and Administrative Proceeding: If you are involved in a lawsuit of a dispute we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process.

Coroners, Medical examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising/Marketing Health-Related Services: We may contact you to provide you with information about our sponsored activities as permitted by law. If you do not wish to receive such information from us, you may opt out. We will not use your health information for marketing communications without your written authorization.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as email, voicemail messages, postcards, or letters).

YOUR HEALTH INFORMATION 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 we cannot practicably 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.

The SmileSpot

Informed Consent Form

This is to reiterate topics of our conversation covered during the consultation concerning braces/banding for you or your child. Excellent orthodontic results can be achieved with informed and cooperative patients. The following information is routinely supplied to anyone considering orthodontic treatment. Like any health care treatment, orthodontics has some inherent risks and limitations. These are seldom enough to contraindicate treatment but should be considered in making the decision to wear braces. Please feel free to ask any questions you may have.

Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully.

The health of the bone and gums that support the tooth may be affected by orthodontic tooth movement if a condition already exists, and in some rare cases where a condition doesn't appear to exist. In general, orthodontic treatment lessens the possibility of tooth loss or gum infections due to misalignment of the teeth or jaws. Inflammation of the gums and loss of supporting bone can occur if bacterial plaque is not removed daily with good oral hygiene.

Decalcification (permanent markings), decay or gum disease can occur is patients do not maintain proper and thorough hygiene throughout treatment. Excellent brushing, flossing, and plaque removal is a must. Sugars and between meal snacks should be eliminated.

During treatment patients may be asked to wear retractors or elastics. These place force on your teeth so they will move into their proper positions. The amount of time worn affects the results. They must be worn as directed. If a retractor is detached from the tubes or archwire hooks while the elastic force is engaged, it can snap back and cause an injury.

Teeth have a tendency to rebound to their original position after treatment. More severe problems have a greater tendency to relapse. Full cooperation in wearing finish appliances is vital. As wisdom teeth develop, your teeth may chance alignment. Your dentist should monitor them in order to determine when and if they will need to be removed.

A non-vital or dead tooth is a possibility. A tooth that has been traumatized from a deep filling or even a minor blow can die over a long period of time with or without orthodontic treatment. An undetected non-vital tooth may flare up during orthodontic movement requiring endodontics (root canal) to maintain it.

Sometimes the root ends of the teeth are shortened during treatment. This is called root resorption. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. It should be noted that there are a number of causes of root resorption other than orthodontics. Under healthy conditions, this is no disadvantage but in the event of gum disease later in life, this could reduce the longevity of the teeth. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal or the appliances prior to the completion of orthodontic treatment.

Occasionally problems may occur in the jaw joints, i.e temporomandibular joints (TMJ), causing joint pain, headaches, or ear problems. These problems may occur with or without orthodontic treatment. Any of the above-noted symptoms should be promptly reported to the orthodontist. Treatment by other medical or dental specialist may be necessary. You can expect minimal imperfection in they way your teeth meet following the end of treatment. An equilibration (selective smoothing or reshaping the tooth) or other special treatment may be recommended by your dentist to improve occlusal or joint relationship. It may also be necessary to remove a small amount of enamel in between the teeth thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Rarely a person who has grown normally and in average proportion may not continue to do so. If growth becomes disproportionate the jaw relation can be affected and original treatment objectives may have to be compromised. This is a biological process and is beyond anyone's control. Surgical assistance may be recommended in these situations.

Informed Consent Form

The total treatment time can be delayed beyond our estimate. Lack of facial growth, poor elastic wear, broken appliances and missed appointments are all important factors that could lengthen treatment time and affect the quality of the result.

Sometimes orthodontic appliances may be accidentally swallowed or aspirated, or may irritate or damage the oral tissues. The gums, cheeks and lip may be scratched or irritated by loose or broken appliances or by blows to the mouth. Usual post-adjustment tenderness should be expected, and the period of tenderness or sensitivity varies with each patient and the procedure performed. (Typical post-adjustment tenderness may last 24-48 hours.) You should inform your orthodontist of any unusual symptoms, or broken or loose appliances, as soon as they are noted.

On rare occasions, when dental instruments are used in the mouth by the orthodontist or assistant, the patient may inadvertently get scratched, poked, or receive a blow to a tooth with potential damage to or soreness to oral structures. Abnormal wear of tooth structures is also possible if the patient grinds the teeth excessively.

In attempting to move impacted teeth (teeth unable to erupt normally), especially cuspids and third molars (wisdom teeth), various problems are sometimes encountered which may lead to periodontal problems, relapse, or loss of teeth. Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth, which you should discuss with your family dentist or oral surgeon prior to the procedure. In addition teeth may become impacted, fused to the bone, or just fail to erupt. Treatment of these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, or replacement.

When clear and tooth colored brackets has been utilized, there have been some reported incidents of patients experiencing bracket breakage and/or damage to teeth including attrition and enamel flaking or fracturing on debonding. Fractured brackets may result in remnants, which might be harmful to the patient especially if swallowed or aspirated.

Due to the wide variation in the size and shape of teeth, achievement of the most ideal result (for example, complete closure of excessive space) may require restorative dental treatment. The most common types of treatment are cosmetic bonding, crown and bridge restorative dental care and/or periodontal therapy. You are encouraged to ask questions regarding dental and medical care adjunctive to orthodontic treatment of those doctors who provide these services.

General medical problems can affect orthodontic treatment. You should keep your orthodontist informed of any changes in your medical health.

I have read and understand the above and consent to treatment. I agree to having photographs, x-rays, and dental models before, during, and after treatment, and to the use of the same by the orthodontist in specific papers or demonstrations.

_____ _____

Patient Name | Parent/Guardian Name (if patient under 18)

_____ _____

Patient Signature (or Parent/Guardian if patient under 18) | Date

The SmileSpot

Patient Acknowledgement of Privacy Practice

As the laws regarding patient privacy are changing, it is our responsibility to notify you about how your records will be handled. This notice describes how medical information about you may be used and/or disclosed including how you can get access to this information and be notified.

PLEASE READ CAREFULLY AND INITIAL that you have read and understand each statement. If you wish to make changes, you must notify our office so that your records can be updated.

_____ I am aware that the "Notify of Privacy Practices" is available for me to read here in the office and I may receive a copy upon request. I understand that you reserve the right to change the terms of this notice and that I may contact you at any time to obtain the most current copy of this notice.

_____ I authorize the staff to disclose my information and obtain payment from third party payers (i.e.-insurance company).

_____ I authorize the staff of this office to release pertinent information to other healthcare providers involved directly or indirectly in my treatment.

_____ I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ I am aware the staff will identify themselves as a doctor's office when confirming appointments, returning my calls, or for routine follow up calls.

_____ I consent to receive electronic messages from the practices at my cell phone and/or e-mail provided and will apply for all future reminders/feedback/health information unless I request a change in writing for refusal to receive electronic communications. Cell phone: _____
Email: _____

_____ I authorize the following person(s) to have access to my medical information, including taking advice regarding my condition, making my appointments, and discussing my billing issues. I also understand that by listing no names, I am not giving authorization to release any of the above to any person(s) other than myself.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____
Patient Name: _____

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) _____

RELEASE AUTHORIZING USE OF PERSONAL LIKENESS

I,_____(patient name) consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by_____(member name) for any lawful use _____ (member name) deems appropriate, including for treatment, advertising his/her/its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational purposes.

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by_____(member name) during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by_____(member name). I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that_____(member name) will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that_____(member name) cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that_____(member name) may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that_____(member name) may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness.

I have read the foregoing in its entirety and understand its terms.

_____ _____ _____
Patient name Patient/guardian signature

_____ _____
If patient is a minor, guardian name relationship to patient Date

_____ _____
Provider signature Date