Nickname: ______ Patient Number: ______

Patients Address: ______ Primary Phone #: ______

Birthdate: ______ Age: ______ Sex: ______

Patient School: ______ Grade/Position: ______

Patient E-mail: ______ Resp Party E-mail: ______

Primary Responsible Party: ______ Relationship to patient: ______

Home Address: ______ Primary Phone #: ______

Employer Name/Address: ______ Alternate Phone #: ______

Secondary Responsible Party: ______ Relationship to patient: ______

Home Address: ______ Primary Phone #: ______

Mother's Name: ______ Father's Name: ______

How Did You Hear About Us? ______ Present Dentist: ______

Reason For Consultation: ______

Please circle any of the following for which the patient has a history:

Medical Conditions

AIDS/HIV	Cancer	Difficulty Breathing	Fainting/Dizziness	Muscular Disorders
Allergies	Cerebral Palsy	Downs Syndrome	Headaches	Nervous Disorders
Anemia	Chest Pains	Drug Allergies	Heart Condition	Perio Problems
Arthritis	Chronic Neck Pain	Emphysema	Hepatitis	Prolonged Bleeding
Asthma	Clicking of Jaw	Emotional Disorders	High/Low Blood Pressure	Psychiatric Treatment
Bone Disorders	Cold Sores/Herpes	Endocrine Problems	Immune Problems	Rheumatic Fever
Bulimia	Diabetes	Epilepsy/ Seizures	Kidney Problems	Scoliosis

Habits

Clenching	Poor Brushing
Grinding	Speech Problems
Finger Sucking	Thumb Sucking
Mouth Breathing	Tongue Thrust
Nail Biting	TMJ Pain
Nursing Bottle Habit	
Pacifier Habit	

Please Mark/ List Allergies: € Latex € Aspirin € Metals/Plastic € Codeine € Erythromycin € Penicillin €Other ______

Other Medical Conditions? ______

Current Medications? ______

Females: Have you started Menstruating? If Yes, what age? ______ Have you had previous orthodontic treatment? ______

Have wisdom teeth been extracted? ______ Any face, mouth or teeth injuries? ______

Are there any missing or extra teeth? ______ Do gums bleed when brushed or flossed? ______

Have the Tonsils and adenoids been removed? ______ Any other questions? ______

Names and Ages of Brothers & Sisters: ______

Insurance Co Name: ______ Insurance Co Address: ______

Insurance Phone #: ______ Group Name/Number: ______

Policy Holder Name: ______ Social Sec/ID #: ______

Policy Holder Birthdate: ______

I authorize the office of Dr. Scott Runnels to release all treatment info to secure payment of benefits, as well as use this signature as authorization to file the initial insurance claim and all future claims on my behalf. I/we are responsible for any amounts not paid by my/our insurance. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature: Relationship To Patient: Date:

HIPPA

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.

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, electronically or physically, in one or more of the following respects:

-To other health care providers (i.e. general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e. phone, email, or fax)
-To third party payors or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account;
-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 other patients, or prospective patients, in print or electronic form for marketing purposes, limited to photos, first names, ages, and basic treatment information;
-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 in the use and disclosure of your protected health information (PHI);
-Request confidential communication of your PHI;
-Inspect and obtain copies of your PHI through asking us;
-Amend or modify your PHI in certain circumstances;
-Receive an accounting of certain disclosures made by us of your PHI; 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 in 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 (PHI) 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; and,
-To advise you of your right to change the terms of the Privacy Notice and to make the new notice provisions effective for all PHI maintained by us, and that if we do so, we will make available to you 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 PHI
-Amend your PHI if, for example, it is accurate and complete; or
-Provide an atmosphere that is totally free of the possibility that your PHI may be incidentally overheard by other patients or 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 our Privacy Contact Person or direct your questions to that person at our office address. Thank you.

Patient Acknowledgement
I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice:

Patient/Parent Signature____ **Date:** ____________________

HIPPA RELEASE FORM

RUNNELS ORTHODONTICS

I, ________________________________authorize the release of information on ________________________________, including the diagnosis, records, examination and treatment rendered to the above patient, ledger and billing, and claims information.

The information may be released to (check all included)

( ) Step parents: ____________________________
( ) Grandparents: ____________________________
( ) Child care providers: ______________________
( ) Other: _________________________________
( ) Information is not to be released to anyone. (Initial Here): __________

In further consideration for this, Runnels Orthodontics agrees to the same stipulations. This Release of Information will remain in effect until terminated by me in writing.

Divorce Case: Responsibility for the financial contract can only be with ONE Responsible Party

- ❑ Mother-Name__________________________
- ❑ Father -Name__________________________
- ❑ Down payment________________
- ❑ ACH Monthly auto draft___________________
- ❑ Downpayment and Monthly Auto Draft
- ❑ Signature needed before delivery of appliance

Responsible Party Name________________________________

Messages and communication from our office:
If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

( ) you may leave a detailed message
( ) please leave a message asking me to return your call
( ) other ______________________________________

The best phone number to reach me at is: ______________________

Signed: ____Date: __/__/__
Witness: _______________________________________Date: __/__/__