Welcome to TINGEY Orthodontics

PATIENT INFORMATION

Name ____________________ Date ________

Nickname ____________________

Address ____________________

City ____________ State ________ Zip ________

Birth date ____________ Age ____________ ☐ M ☐ F

Home Phone Number ____________________

Student/School ____________________

Favorite Sports or Hobbies ____________________

Incase of an Emergency Contact ____________________

Phone ____________ Relation ____________

General Dentist ____________________

REFERRAL

WHO MAY WE THANK FOR REFERRING YOU?

☐ Dentist ____________________

☐ Friend ____________________

☐ Yellow pages ____________________

☐ Internet ____________________

☐ Other ____________________

PARENT INFORMATION

Email ____________________

Mother's Information

Name ____________________ DOB ________

Address ____________________

City ____________ State ________ Zip ________

Hm Phone ____________ Cell Phone ____________

Father's Information

Name ____________________ DOB ________

Address ____________________

City ____________ State ________ Zip ________

Hm Phone ____________ Cell Phone ____________

The parent or guardian who accompanies the child is responsible for payment.

DENTAL INSURANCE ONLY

Insured Name ____________________

Employer ____________________

ID # ____________________

Group # ____________________

Insured Name ____________________

Employer ____________________

ID # ____________________

Group # ____________________

MEDICAL HISTORY

Yes No Heart Murmur
Yes No Asthma
Yes No Rheumatic Fever
Yes No Tuberculosis
Yes No Prolonged Bleeding
Yes No Cancer
Yes No Anemia
Yes No Growth Disorders
Yes No Kidney Disease
Yes No Disabilities
Yes No Liver Disease
Yes No Emotional Problems
Yes No Diabetes
Yes No Fever Blisters
Yes No Hepatitis
Yes No Allergies to Latex/Metal
Yes No Epilepsy
Yes No Allergies to Medication ____________
Yes No Fainting

Have tonsils or adenoids been removed? Yes No

Any health issues we should know about? Yes No

Growth Information: Because growth can be an important factor in orthodontic treatment planning, your answers to the following are needed to aid in our selection of treatment alternatives:

Has your child reached puberty yet? Y N

GIRLS: Has she started her cycle? Y N

If yes When? ____________

If yes **BOYS:** Has his voice changed? Y N

When? ____________

Father's Height ________ Mother's Height ________

Please indicate history of:

Y N Thumb/Finger Sucking
Y N Jaw Joint Problems
Y N Mouth Breathing
Y N Frequent Headaches
Y N Tongue Thrust
Y N Speech Problems

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

I certify that the information that I have given today is complete and accurate. I understand that it is my responsibility to inform the office of any changes.

Signature of Parent or Guardian ______________________________ Date ____________

PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records.

Please check the following:

☐Yes ☐ No **I consent to the taking of photographs, x-rays, and models before, during and after treatment. Dr. Tingey may share the same with other dentists in regard to my treatment.**

☐Yes ☐ No **I consent to my picture being placed on the *in-office* bulletin board when appliances are removed.**

☐Yes ☐ No **If you were referred by your doctor or a friend may we thank them?**

Yes No As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient name: ____ Date: _______________
Signature: ____ Date: ____________________
(parent or guardian if patient is under the age of 18)

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:
The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, manager and doctor continually undergo training so that they may understand and comply with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule” .We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.
It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.
We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization or retaliation if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any service problem so that we may remedy the situation promptly.

THANK YOU FOR BEING ONE OF OUR HIGHLY VALUED PATIENTS.