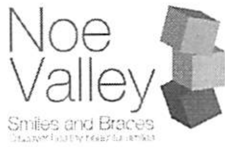


NOE VALLEY SMILES AND BRACES
CAROLINE HOCKING, DDS, MmSc

Date: ____________

Patient Information

Patient's Full Name______________________________________ Age ________ Sex (M) (F)

Nickname (if any) ____________________Birthdate ______________ SSN _________________

Whom may we thank for referring you _______________________________________

Home Address ____ Home Phone ___________

Employer____ Cell Phone ___________

Business Address ____ Work Phone ___________

E-mail Address ___________________________

Responsible Party If Applicable

Father (full name) _______________________SSN _______________ Birthdate _____________

Mother (full name) _______________________SSN _______________Birthdate _____________

Parent(s) are: Married Divorced Single Widowed Partners Child lives with: ________________

Home Address ____________________________Zip Code_________ Home Phone ___________

Father's Employer____ Cell Phone _____________

Business Address ____ Work Phone ___________

Mother's Employer ____Cell Phone _____________

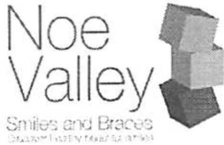
Business Address ____ Work Phone ___________

E-mail Address _______________________ Person Financially responsible _____________________

Emergency Contact ______________________________________ Phone ____________________

How would How would you like us to contact you? Home Work Cell E-mail

SIGNATURE ______________________________________ Relationship ____________________



Name: ______________________

Health History

Patient's Physician: ______________________ Telephone #______________

Have you had any unfavorable reactions to drugs, antibiotics or anesthetics? (Y) (N)

If yes, please list ____

Are you currently taking any medications? (Y) (N) What kind? ______________________

Do you currently, or have you ever had any of the following?

ADHD/ADD	(Y)	(N)	Bone Disorder	(Y)	(N)
Delayed Development	(Y)	(N)	Cancer/Malignancy	(Y)	(N)
Down's Syndrome	(Y)	(N)	Chemo/Radiation Therapy	(Y)	(N)
Autism	(Y)	(N)	Cystic Fibrosis	(Y)	(N)
Asthma/lung problems	(Y)	(N)	Allergies to Meds	(Y)	(N)
Tuberculosis	(Y)	(N)	Diabetes	(Y)	(N)
Anemia	(Y)	(N)	Arthritis/Joint problems	(Y)	(N)
Bleeding Disorder	(Y)	(N)	Cardiac Disease/Heart	(Y)	(N)
Bruising	(Y)	(N)	Epilepsy/Seizure	(Y)	(N)
Hepatitis	(Y)	(N)	Bladder problems	(Y)	(N)
Brain Injury	(Y)	(N)	Cerebral Palsy	(Y)	(N)
Earaches/Infections	(Y)	(N)	Emotional/School Problems	(Y)	(N)
Hearing Impaired	(Y)	(N)	Depression/Anxiety	(Y)	(N)
Rheumatic Fever	(Y)	(N)	Eating Disorder	(Y)	(N)

Dental History

Name of your dentist? ______________________ Phone ______________

Date of last visit ______________ Were X-rays taken? (Y) (N)

Have you had any injuries to teeth, mouth or head? (Y)(N) Please describe: ______________________

Do you have any of the following habits? (past or present)? Please circle: Thumb/finger-sucking Nail-biting Lip-sucking Mouth-breathing Teeth-Grinding Snoring

How often do you brush your teeth per day? ____________ How often do you floss? ______________

What is the main reason for visiting the orthodontist today?______________________________

I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my health status. I understand that by signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage.

Patient Signature: ______________________________ Date______________

Parent/GuardianSignature: ______________________________ Date______________

Doctor'sSignature: ______________________________ Date______________

Name: ______________________________

Insurance Information

Primary Insurance Company ____________________________________ Phone Number ______________

Subscriber ______________________________ Birthdate ______________ Group Number ______________

Secondary Insurance Company ____________________________________ Phone Number ______________

Subscriber ______________________________ Birthdate ______________ Group Number ______________

As a courtesy to our patients, we will file your insurance claim with the insurance company listed above for treatments your child receives. However, in the event the insurance company, for any reason, does not pay, the balance will become your responsibility, and will be billed directly to you. You understand that this contract is with Noe Valley Smiles and Braces and yourself, and you are responsible for all charges on the account.

SIGNATURE OF RESPONSIBLE PARTY ____

Relationship ____ Date ____________________________

Patient Name: ______________________

Confirmation & Cancellation Policy

Noe Valley Smiles & Braces understands that your time is very valuable and we hope you agree that our time is equally valuable. It is with that understanding that we have implemented a 48 business hour cancellation policy. If an appointment is cancelled with less than 48 business hours notice you will be subject to a cancellation fee based on the amount of time that you have reserved. You are responsible for confirming all appointments via phone or email 24 hours in advance to secure your appointment time.

Consent for Electronic Communications

We provide our patients the option to participate in our electronic communications system. Some of these features include the ability to:

· *Request appointments online*

· *Confirm appointments via e-mail*

· *Receive text message appointment reminders*

· *Submit patient satisfaction surveys*

· *Refer friends and family online*

You may opt out of our electronic communications systems at any time by clicking "unsubscribe" link found in the footer of each e-mail or by replying to a text message with 'STOP.' Standard text messaging rates apply.

☐ Check here to opt out of text message communication.

☐ Check here to opt out of e-mail communication.

** We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for this dental practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for this dental practice in the administration of your benefits. Our affiliates do not sell, share, or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.*

SIGNATURE OF RESPONSIBLE PARTY: ______________________

Relationship: ______________________ Date: ______________________

Noe Valley Smiles and Braces

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

Last Updated April 1, 2011

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

____
Patient Name (Please Print)

________________________________ ________________________________
Patient Signature Date

OR

____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: __________________________

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:____

________________________________ ________________________________
Staff Member Signature Date