TODAYS DATE: _____

PATIENT INFORMATION:

Name: _____ **Prefers to be called:** _____

Gender: ___Male Female Other

DOB: _____ **Age:** _____ **School/Grade:**_____

Home Address: _____

RESPONSIBLE PARTIES:

Parent #1's Name: _____ **Parent #2 & Name:**_____

Parent #1's Address: _____ **Parent #2's Address:** _____

_____ _____

Parent #1's Phone:_____ **Parent #2's Phone:**_____

Parent #1's Employer: _____ **Parent #2's Employer:** _____

Parent #1's Occupation: _____ **Parent #2's Occupation:** _____

Parent #1's Email: _____ **Parent #2's Email:** _____

Parent's Marital Status: ___Married Divorced Separated Single Widowed

If divorced, who is the custodial parent? _____

Indicate which parent should receive correspondence: ___Parent #1 Parent #2 Both

DOCTOR INFORMATION: **Child's Dentist:** _____

PERSONAL INFORMATION:

What are your child's hobbies and interests? _____

_____

Are there any siblings in the family? Please list. _____

If so, what are their ages? _____

Would you be interested to learn more about Invisalign treatment for Adults? _____Yes No

HEALTH INFORMATION:

Is your child taking any medication regularly? Yes No

If so, please list: _____

Is your child allergic to any food, drug, or medicine? Yes No

If so, please list: _____

Does your child have any illnesses/disease we should be aware of? Yes No

If so, please list: _____

Has your child had a recent surgery? Yes No

If so, please explain: _____

Has your child had their tonsils and or adenoids removed? Yes No

Has your child had any accidents or injuries relating to their face, teeth, or head? Yes No

If so, please explain: _____

Did your child suck their thumb or fingers past the age of three? Yes No

Does your child currently suck their thumb or fingers? Yes No

Has your child had any other oral habits (nail biting, lip biting, cheek biting, etc.)? Yes No

If so, please explain: _____

Does your child grind or clench their teeth? Yes No

Does your child have pain in their jaw joint when opening, chewing, or yawning? Yes No

Did your child's baby teeth erupt on time (6-9 months of age)? Yes No

Did your child's adult teeth come in on time? Yes No

Has your child had any teeth extracted? Yes No

If so, please explain: _____

Parent's Signature: _____ **Date:** _____

1 Grant Square, Suite #101 | Hinsdale, IL 60521| (630) 323-1201 | Fax (630) 325-7039

www.chtortho.com

CHT Orthodontics
Privacy Policy/HIPAA Compliance

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for such health care.

Our Legal Duty

We are required by 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. These policies took effect April 14, 2003 and will remain in effect until amended by our office.

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 effective for all health information that we collect and maintain, including prior health information. As changes in our privacy practices are made, we will notify our patients of these changes and make amended office Policy statements available upon request.

Our patients are welcome to request a copy of our privacy policies at any time. Please keep this information on file with other documents from our office and check with us for any amended versions or changes.

Uses and Disclosures of Health Information

Treatment: We may use or disclose your health information to a dentist or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment via mail, fax, or electronic transmission for services we provide to you.

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 personnel who work in our office, evaluating practitioner and provider performances, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Disclosure to Family and Friends: You have the right for us to disclose your own personal health information to you as described in the Patients' Rights section of the Privacy Policies. We may also disclose your health information to a family member, friends, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the identification of you or a family member in conjunction with a forensic investigation. In the event of your incapacity or in emergency circumstances, we will disclose health information based on our own professional judgement. In that instance, we will disclose only that information that is directly relevant to the treating entity's involvement in your health care. 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, dental supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

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

Minimal Necessary Disclosures: We will not make disclosures of your health information to a greater degree than we consider minimally necessary for the purposes of each disclosure.

Access: You have the right to look at or obtain copies of your health information with limited exceptions. Illinois law (R-156-69-502-7) specifies that original records must remain in the possession of the treating dentist for seven years. 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. Your request needs to be in writing. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $0.10 for each page, an administrative fee of $20.00 for staff time to locate and 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 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 for a full explanation of our duplication 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 the case of 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. Your request must be in writing and 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 reserve the right to deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision 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 your by alternative means or at alternative locations, you may complain to us using the contact information listed below. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your compliant with the Department of Health and Human Services 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 us or with the US Department of Health and Human Services. This notice was published and became effective as of April 14, 2003.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Name: _____

Signature: _____ Date: _____

Please allow the below parties to receive information regarding patient:

Name: _____ Relation to Patient: _____ Phone Number: _____

Name: _____ Relation to Patient: _____ Phone Number: _____