

Welcome to our practice!

We would like to welcome you and your child to our office. Our goal is to make your visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Please tell us about your child: (please print)

Today's date: _____

Child's Name: _____ Male _____ Female _____

Nickname: _____ Child's Birth Date: ____/____/____ Age: _____ Pronouns: _____

Child's home phone #: _____ Email Address _____

Child's home address: _____
City State Zip

Rent or Own: _____ Years at current residence: _____

All appointments will be confirmed via text: Cell # _____

School: _____ Grade: _____ Class of: _____

Hobbies/Sports: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Child's Dentist _____ Did they refer you to us? _____ Yes _____ No

What are the main concerns that you would like orthodontics to address? _____

Who is accompanying your child today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes _____ No _____

List brothers / sisters and ages: _____

Parents' Martial Status: _____ single _____ married _____ widowed _____ divorced _____ separated

Mother's Information _____ Step Mother _____ Guardian _____ E-mail: _____

Name: _____ Birth Date: ____/____/____

Home#: (____) _____ Alt #: (____) _____

Employer: _____ How long at current job: _____ Job Title: _____

SS #: _____

Father's Information _____ Step father _____ Guardian _____ E-mail: _____

Name: _____ Birth Date: ____/____/____

Home#: (____) _____ Alt #: (____) _____

Employer: _____ How long at current job: _____ Job Title: _____

SS #: _____

Person responsible for account

Name: _____ Relation: _____

Home #: (____) _____ Work #: (____) _____ ext _____

Who will be making appointments? _____ Best time to call? _____

Name: _____ Cell#: (____) _____ Hm#: (____) _____

Primary Orthodontic Insurance

Coverage? yes no

Insurance Co. Name: _____ Phone #: _____

Insurance Co. Address: _____

Group #: _____ Policy owner's name: _____

Relationship to patient: _____ Birth date: ____/____/____

SS# or ID #: _____ Policy owner's employer: _____

Secondary Orthodontic Insurance

Coverage? yes no

Insurance Co. Name: _____ Phone #: _____

Insurance Co. Address: _____

Group #: _____ Policy owner's name: _____

Relationship to patient: _____ Birth date: ____/____/____

SS# or ID #: _____ Policy owner's employer: _____

Has your child ever been evaluated for or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

List any musical instruments played: _____

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain / tenderness in his/ her jaw joint (TMJ/TMD)? Yes No

Does your child brush his /her teeth daily? Yes No

Floss his/ her teeth daily? Yes No

Child's Physician: _____ Phone #(____) _____ Date of last visit _____

Is your child currently under the care of a physician? Yes No

Has puberty begun? Yes No

Has menstruation begun? (Girls) Yes No

Are you pregnant? Yes No

Please describe your child's current physical health: Good Fair Poor

Please list all drugs that your child is currently taking: _____

Has your child ever had any of the following medical problems?

	Yes	No		Yes	No		Yes	No
Abnormal bleeding			Diabetes			Asthma		
Handicaps/Disabilities			Hemophilia			Hearing impairment		
Allergies to any drugs			Heart Murmur			Any hospital stays		
Allergy to Latex?			Any operations			Hepatitis		
Allergy to Metals?			HIV + / AIDS			Cancer		
Kidney/liver problems			Congenital heart defect			Rheumatic/ Scarlet fever		
Convulsions/ Epilepsy			Tuberculosis (TB)			Any other Allergies?		

Please comment on any (Yes) answers _____

Please list any habits (thumb, finger sucking, nail biting, etc.) that your child has or had in the past. _____

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. I consent to treatment evaluation (including x-rays, photos, and treatment planning).

Signature of parent or guardian _____ Date _____

I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance. I understand that I am responsible for any portion my insurance carrier does not pay

Signature of parent or guardian _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

Dr. Jeffrey E. Kashner Orthodontics
27015 169th Place SE Suite 201
Covington, WA 98042

*** You May Refuse to Sign This Acknowledgment***

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

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Sleep Apnea Questionnaire

Name: _____

Date: _____

Your age: _____ Your sex: ___ Male ___ Female

Please complete the following:

Obstructive sleep apnea symptoms

Do you fall asleep during the day?	Yes	No
Have you fallen asleep while driving?	Yes	No
Do you have disrupted sleep?	Yes	No
Do you urinate frequently during the night?	Yes	No
Do you snore heavily at night?	Yes	No
Do you talk in your sleep?	Yes	No
Do you suffer from daytime fatigue?	Yes	No
Do you experience daytime sleepiness?	Yes	No
Have you had recent weight gain?	Yes	No
Do you have high blood pressure?	Yes	No
Do you take blood pressure medication?	Yes	No
Do you have an irregular heartbeat?	Yes	No
Do you suffer from depression?	Yes	No
Do you have headaches when you wake up?	Yes	No
Does your spouse see you stop breathing during sleep?	Yes	No
Do you drink alcoholic beverages?	Yes	No
Do you take sedative-type medication?	Yes	No

Airway

Do you have difficulty breathing through your nose?	Yes	No
Are you a mouth breather?	Yes	No
Do you have difficulty closing your lips?	Yes	No
Do you have dry mouth problems?	Yes	No
Do you have speech clarity problems?	Yes	No

Please continue on backside >



How do you control your sleep apnea?

Restrict alcoholic beverages

Restrict sedative medication

Sleep upright

Sleep on side

Sleep on back

Sleep with special pillow positions

Other:

Have you had treatment for sleep apnea?

Weight loss

CPAP (continuous positive airway pressure)

Dental appliance

Soft palate surgery

Nasal Surgery

Other:

Epworth Sleepiness Scale

Patients Name _____ Date _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

- 0 = Would *never* doze
- 1 = *Slight* change of dozing
- 2 = *Moderate* chance of dozing
- 3 = *High* chance of dozing

Situation	Chance of Dozing or Sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
Total Score (add the scores up) (This is your Epworth score)	



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Covington, WA 98042

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 law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **5/20/2014**, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your 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:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government 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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health 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 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.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or 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 instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

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 the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

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 if 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 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 the U.S. Department of Health and Human Services.

Our Privacy Official: *Dr. Jeffrey E. Kashner DDS, MSD, PLLC*

Telephone: *(253) 630-3331* Fax: *(253) 630-6881*

Address: *27015 169th Place SE Suite 201 Covington, WA 98042*

E-mail: *info@nicesmilesonline.com*

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