**Pritchett Orthodontics**
Charles E. Pritchett, D.D.S., M.S.D.
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Specialists in Orthodontics

9602 E. Washington St.
Indianapolis, IN 46229
Office: (317) 898-9473

45 Green Meadows Drive
Greenfield, IN 46140
Office: (317) 462-4151

## Patient's Information

Date _____ Date of Birth _____ Age _____ Sex ____

Patient's Name _____
Last First Middle

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____
Street City State Zip

Other family members seen by us: _____

Family Dentist: _____ Referred By: _____

## Responsible Party Information

Parent/Guardian Name _____
Last First Middle

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Parent/Guardian Name _____
Last First Middle

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Email Address _____

Closest Relative Not Living with Patient _____
Name Phone

In case of Emergency Please notify _____
Name Phone

Does Patient currently obtain Orthodontic Coverage? _____ **Yes** _____ **No**

Date:_____

# INSURANCE FORM

Patient ID#:_____

Patient Name:_____ DOB:_____-_____-_____

## PRIMARY

Policy Holder:_____ Relation:_____

I.D. Number:_____ SSN: _____-_____-_____

DOB:_____-_____-_____ Call Back#: _____-_____-_____

Policy Holder's Employer:_____

Insurance Co:_____ Phone:_____-_____-_____

Claims Address: P.O. Box _____ City:_____ St:_____

Zip:_____ Group# (Plan, Local or Policy#):_____

**OFFICE USE** LTM:$_____ @ _____% Used:$_____ Pays: _____ Auto Int DP:_____% Ded:_____

Wait: Y N _____mos. WIP:_____ Age Lmt:_____ COB:_____ Eff Date:_____ Payer ID:_____

## SECONDARY

Policy Holder:_____ Relation:_____

I.D. Number:_____ SSN:_____-_____-_____

DOB:_____-_____-_____ Call Back#:_____-_____-_____

Policy Holder's Employer:_____

Insurance Co:_____ Phone:_____-_____-_____

Claims Address: P.O. Box _____ City:_____ St:_____

Zip:_____ Group# (Plan, Local or Policy#):_____

**OFFICE USE** LTM:$_____ @ _____% Used:$_____ Pays: _____ Auto Int DP:_____% Ded:$_____

Wait: Y N _____mos. WIP:_____ Age Lmt:_____ COB:_____ Eff Date:_____ Payer ID:_____

**Banding:**_____ **Amount:**$_____ **Records:**_____

This x-ray is a copy of the original.
You may keep it for your office records.

## DENTAL HISTORY

Patient's Name _____

Date of last dental exam (month and year) _____

| | | |
|---|---|---|
| Are patient's teeth brushed thoroughly at least twice each day? | ☐ Yes | ☐ No |
| Do gums often bleed while brushing? | ☐ Yes | ☐ No |
| Does patient floss regularly? | ☐ Yes | ☐ No |
| Does patient use home fluoride rinses? | ☐ Yes | ☐ No |
| Has patient complained of pain or clicking in the jaw joints? | ☐ Yes | ☐ No |
| Has the jaw ever locked in an open or closed position? | ☐ Yes | ☐ No |
| Have any teeth been removed by a dentist? | ☐ Yes | ☐ No |
| Has there been any serious injury to the face, mouth or teeth? | ☐ Yes | ☐ No |

If so, please describe _____

Please check any of the following conditions patient has had:

___ Allergies/hay fever
___ Mouth breathing
___ Sinus problems
___ Speech problems
___ Sores in mouth
___ Frequently stuffy nose
___ Frequent sore throat or colds
___ Thumb/finger sucking (age stopped? ___ )
___ Musical instrument (what? ___ )
___ Tooth grinding or clenching habit

## MEDICAL HISTORY

| | | |
|---|---|---|
| Currently (or recently) under medical care? | ☐ Yes | ☐ No |
| If so, please describe _____ | | |
| Does patient have any emotional, mental or physical handicaps or limitations? | ☐ Yes | ☐ No |
| If so, please describe _____ | | |
| Taking any medications or drugs? | ☐ Yes | ☐ No |
| If so, please list _____ | | |
| Ever been seriously ill or treated in a hospital or emergency room? | ☐ Yes | ☐ No |
| If so, please describe _____ | | |
| Have tonsils been removed? (at age _____ ) | ☐ Yes | ☐ No |
| Have adenoids been removed? (at age _____ ) | ☐ Yes | ☐ No |
| Is patient pregnant? | ☐ Yes | ☐ No |

Please check any of the following conditions patient has had:

___ heart condition/murmur
___ high blood pressure
___ rheumatic fever
___ abnormal bleeding
___ tumor or growth
___ hearing problems
___ arthritis
___ asthma
___ diabetes
___ epilepsy
___ hepatitis
___ tuberculosis
___ tourettes syndrome
___ sexually transmitted disease
___ Fainting or dizziness
___ AIDS or HIV infection
___ drug or allergy reaction, to: _____

Please provide any additional information about the patient's dental and medical history that may be important to his/her dental care: _____

PRITCHETT ORTHODONTICS

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ E-mail:_____

Patient #_____ Social Security # _____

## SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health informations, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jeanie

Telephone: (317) 898-9473 Fax:_____

E-mail:_____

Address: 9602 E. Washington Street, Suite F, Indianapolis, IN 46229

**Right to Revoke:** You will the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**

PRITCHETT ORTHODONTICS

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**"You May Refuse To Sign This Acknowledgement"**

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

_____
**Please Print Name**

_____
**Signature**

_____
**Date**

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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PRITCHETT ORTHODONTICS

# 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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

## OUR LEGAL DUTY

We are required by applicable 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. This Notice takes effect April Fourteenth, Two Thousand and Three, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment 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 healthcare professionals, evaluating practitioner and provider performance, 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 is was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with 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 notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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, medical 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 authorization.

**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.