

Orthodontic Specialists for Children and Adolescents

To The Parents/Guardians of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Thank you for choosing our office for your orthodontic treatment. Your appointment for an orthodontic consultation is scheduled for

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Enclosed you will find an Orthodontic Acquaintance Card and several forms. Please complete all forms and bring them along with your insurance card(s) and insurance information to your consultation appointment.

Please note that a parent or legal guardian for the initial consultation MUST accompany any child under the age of 18.

If you have any questions, please feel free to call our office at 215-283-2440.

Sincerely,

DelliGatti and Milewski Orthodontic Group

**Welcome**

Please fill out our survey so that we may batter serve your orthodontic needs

Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?

1. Pediatric Dental Associates Referral
2. Friend - If so whom may we thank? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. General Dentist/Pediatrician - Name of Dentist/Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Intemet/Website-www.teethforkids.com
5. Billboard
6. Newspaper
7. Yellow Pages
8. Insurance company-If so which company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen our ads at any of the following locations?

1. Bus shelter C. Billboard E. Newspaper
2. Train Station D. Back of a bus F. Church Bulletin

If yes, did this Influence your decision to visit our office?

1. Yes
2. No

Have you ever seen our website?

1. Yes
2. No

If yes, how did you get our website address?

1. Billboard
2. Yellow pages
3. Newspaper ad
4. Insurance company
5. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have difficulty finding our office?

1. Yes
2. No

What helped you to make the decision to use our services? Please check your top three

\_\_\_\_\_\_ Insurance \_\_\_\_\_ Reputation of Doctors \_\_\_\_\_ Location \_\_\_\_\_ Doctor’s Referral

\_\_\_\_\_\_ Convenient Hours \_\_\_\_\_\_\_\_ Recommendation of Friend

Thank you for taking the time to answer these questions. We hope that this will ultimately lead to a better understanding of our patient’s needs. During the course of your child's treatment, please feel free to provide us with any suggestions you may have. Should you have any questions, please feel free to ask at anytime.

**Office Policy Regarding Insurance Payments**

* We will arrange your payment plan according to the insurance Plan(s) you have at the onset of treatment.
* If your insurance denies payment for any office procedures performed, you will be responsible for the balance in full.
* If your insurance carrier follows a fee schedule and your coverage is terminated before treatment has been completed, we reserve the right to adjust the fee according to our customary office fee schedule. Any unpaid balance will be due before the braces are removed.
* If you obtain another insurance plan, it is your responsibility to contact the office with your new information. Any insurance change will be submitted as a courtesy to you. Many insurance plans **DO NOT** cover treatment “in progress". The amount still due from your previous carrier will then become your immediate responsibility. Payment cannot be interrupted.
* If your insurance coverage is terminated and you do not have a new plan, any remaining insurance balance becomes your immediate responsibility.

PLEASE SIGN TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION, THANK YOU

Signature Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ORTHODONTIC FINANCIAL INFORMATION**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/LEGAL GUARDIAN**

Mother’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother's DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mothers Cellphone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father's DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's Address (if different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father's Cellphone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION (ALL DENTAL INSURANCE CARRIERS FOR PATIENT MUST BE LISTED)**

\*\* Primary Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payroll # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* Secondary Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payroll # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/LEGAL GUARDIAN RESPONSIBLE FOR ORTHODONTIC ACCOUNT**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Parent/Guardian responsible for orthodontic account)

Email address for responsible party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ORTHODONTIC ACQUAINTANCE CARD**

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First

PARENT’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INTIAL \_\_\_\_ AGE \_\_\_\_ SEX \_\_\_

RES. ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TELEPHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE \_\_\_\_\_\_\_\_\_\_\_ REFERRED BY \_\_\_\_\_\_\_\_\_\_\_

PATIENT’S DENTIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHYSIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYED BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUS. TELEPHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS IF DIFFERENT FROM PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYED BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUS. TELEPHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS IF DIFFERENT FROM PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAMES AND AGES OF OTHER CHILDREN IN FAMILY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

IS PATIENT IN GOOD HEALTH? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? \_\_\_\_\_\_\_\_\_\_\_\_ Yes No

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN

FOR ILLNESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes No

PLEASE LIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/ARC/HIV+ \_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANEMIA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASTHMA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLOOD PRESSURES \_\_\_\_\_\_\_\_\_\_\_\_\_

DIABETES, YEAR DIAGNOSED\_\_\_\_\_\_\_\_\_

EPILEPSY \_\_\_\_\_\_\_\_\_\_\_\_\_

EXCESSIVE BLEEDING \_\_\_\_\_\_\_\_\_\_\_\_\_

FAINTING SPELLS OR SEIZURES \_\_\_\_\_\_

HAY FEVER \_\_\_\_\_\_\_\_\_\_

HEAD INJURIES \_\_\_\_\_\_\_\_\_\_\_\_

HEART DISEASE \_\_\_\_\_\_\_\_\_\_\_\_\_

HEART MURMUR \_\_\_\_\_\_\_\_\_\_\_\_\_

HEPATITIS, JAUNDICE, LIVER DISEASE \_\_\_\_\_\_\_

HIGH BLOOD PRESSURE \_\_\_\_\_\_\_\_\_\_\_\_\_

KIDNEY DISEASE \_\_\_\_\_\_\_\_\_\_\_\_

MENTAL \_\_\_\_\_\_\_\_\_\_\_\_

MITRAL VALVE PROLAPSE \_\_\_\_\_\_\_\_\_\_\_

NERVE DISORDERS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RADIATION TREATMENT \_\_\_\_\_\_\_\_\_\_\_\_\_

RESPIRATORY TREATMENT \_\_\_\_\_\_\_\_\_\_

RHEUMATIC FEVER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RHEUMATISM ARTHRITIS \_\_\_\_\_\_\_\_\_\_\_\_

SINUS TROUBLES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STROKE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STOMUCH ULCERS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TUBERCULOSIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TUMORS OR GROWTHS\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VENEREAL DISEASE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOES PATIENT HAVE TENDENCY TO

COLDS SORE TUROATS EAR INFECTIONS

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? \_\_\_\_\_\_\_ Yes No

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN GIVE REASONS: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY ALLERGIES OR DRUG SENSITIVITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS THE PATIENT REACHED PUBERTY?

GIRLS – HAS SHE STARTED MENSTRUATION Yes No

BOYS – HAS HIS VOICE CHANGED

HEIGHT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL HISTORY OF PATIENT

HAS THERE BEEN ANY INJURIES TO FACE, MOUTH OR TEETH? \_\_\_\_\_\_\_\_\_\_ Yes No

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS?

UNTIL WHAT AGE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

IS THE PATIENT A MOUTH BREATHER? WHIE AWAKE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

WHILE ASLEEP?

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? \_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

LIST ANY MUSICAL INSTRUMENTS PLAYED; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

**DO YOU HAVE OR USE ANY OF THE FOLLOWING?**

TEETH SENSITIVE TO HEAT, COLD SWEETS OR PRESSURE \_\_\_\_\_\_\_\_\_\_\_\_

BLEEDING GUMS, HOW LONG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FREQUENT BLISTERS ON LIPS OR MOUTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SWELLING OR LUMPS IN MOUTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMPLICATIONS FROM EXTRACTIONS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINCHING OR GRIDING \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BURNING OF TONGE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FINGERNAIL BITING, CHEEK BITING \_\_\_\_\_\_\_\_\_\_\_\_\_

CIGARETTES, SMOKING \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUM TREATMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UNPLEASANT TASTE \_\_\_\_\_\_\_\_\_\_\_\_\_\_

BAD BREATH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTERDENTALS STIMULATORS \_\_\_\_\_\_\_\_\_\_\_\_\_\_

BRANDNAME OF MOUTHWASH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORTHODONTIC TREATMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FLOURIC TREATMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DISCLOSING TABLETS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLICKING OF JAW \_\_\_\_ NECKACHES \_\_\_ EAR RINGING \_\_\_ PRIOR ORTHODONTICS \_\_\_

LOCKING OF JAW \_\_\_\_ BACKACHES \_\_\_ EAR ACHE \_\_\_\_ PREVIOUS DENTAL SPLINT

DIFICULTY IN CHEWING \_\_\_\_\_\_\_ JAW PAIN \_\_\_\_ TRERAPY OR NITEGURD\_\_\_\_\_\_

FREQUENT HEADACHES \_\_\_\_\_\_ JAW INJURY \_\_\_\_ PREVIOUS TOOTH ADJUSTMENT

BY GRIDING \_\_\_\_\_\_\_\_\_\_\_\_\_

WISDOM TOOTH REMOVAL \_\_\_\_\_\_\_\_\_

WHEN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR CONSULTATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

\*PRIMARY CARRIER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF INSURED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURED BIRTH DATE \_\_\_\_\_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PAYROLL # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*SECONDARY CARRIER

NAME OF INSURED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURED BIRTH DATE \_\_\_\_\_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PAYROLL # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Parent’s Signature***

***Date***

**DelliGatti and Milewski Orthodontic Group**

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE 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 your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice effective April 14, 2003. We do reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you may be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

* A release of information contained in financial and or medical records
* Diseases spread person to person
* Drug and or alcohol abuse
* Medical History
* Treatment in progress
* Any other related facts

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management
3. Any personal care facility where you Jive
4. Any other doctor providing your care
5. Family members and other people who are part of your plan for service
6. State and Federal agencies acting on behalf of programs such as Medicare or Medicaid
7. Other health care people to start treatment

We may contact you via telephone, postcard or other mailings to:

1. Provide appointment reminders
2. Discuss issues involving payments on your account

We may use a sign-in sheet for:

1. The purpose of keeping track of patients that are being seen on a daily basis. This sheet is destroyed at the completion of each day.

We may take photographs to:

1. Use for decisions made in dental treatment
2. Posting within our offices for the' purpose of showing the progression of treatment

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment
2. Where significant barriers to communication with you exist and we determine that the consent is clearly inferred from the situation
3. Where we are required by law to obtain treatment and we are unable to obtain consent
4. For certain public health activities, such as reporting injuries, death, diseases, etc.
5. Where the use or disclosure is required by law
6. Where we reasonably believe you are a victim of abuse, neglect or domestic violence
7. To coroners, medical examiners and funeral directors.
8. For certain research purposes
9. For Workman’s Compensation purposes
10. For specialized government functions; including custodial situations

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules),
2. To a family member, friend or other-person you choose, who may assist in your care or payment for care

**YOUR RIGHTS**

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you; however, we are not required to agree to the requested restrictions
2. Receive confidential communication by giving us another address
3. Inspect and receive a copy of protected health data by tilling out our-request form
4. Receive a list of disclosures made of your protected health data by filling out our request form
5. Amend protected health data by filing out our request form
6. Obtain a copy of this notice at any time

**COMPLAINTS**

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy, rights have been violated. The complaint must be filed in writing with-us and must state the specific incident(s) including the date, what happened and details of the incident.

For details about tiling a complaint with us, contact:

Megan Green, HIPAA Compliance Officer

Pediatric Dental Associates

6404 Roosevelt Boulevard

Philadelphia, PA 19149

215-743-3700 ext.130

Kathy Bertino, HIPAA Complaint Officer

Cichetti & DelliGatti Orthodontics, P.C.

6404 Roosevelt Boulevard

Philadelphia, PA 19149

215-743-3700 ext. 134

ACKNOWLEDGEMENT

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I hereby certify that I have received a copy of Cichetti & DelliGatti Orthodontics, P.C. notice of Privacy Practices,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_

Printed Name of Recipient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Recipient

**FOR OFFICIAL USE ONLY**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Communication barriers prohibited obtaining the-acknowledgement

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ An emergency prevented us from obtaining acknowledgement

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other (Please specify)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_