

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ Age: _____ Sex: Male Female I Prefer to be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: _____

Patient's Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Years at above address: _____ If less than 5 years, previous address: _____

Patient is: Single Married Widowed Separated Divorced

Occupation: _____ Employer: _____ Years with employer: _____

Business Phone No: _____

Name of Spouse/Closest Relative: _____ Relationship to you: _____

Address (if different than yours): _____

Dentist's name: _____ Phone: _____

Address: _____

Physician's name: _____ Phone: _____

Address: _____

PERSON OR PERSONS RESPONSIBLE FOR ACCOUNT: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____ State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____ State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

MEDICAL HISTORY : Now or in the past, have you had:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Birth defects or hereditary problems?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bone fractures, any major accidents?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatoid or arthritic conditions?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Endocrine or thyroid problems?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Kidney problems?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Diabetes?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cancer, tumor, radiation treatment or chemotherapy?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Stomach ulcer or hyperacidity?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Polio, mononucleosis, tuberculosis or pneumonia?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Problems of the immune system?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	AIDS or HIV positive?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hepatitis, jaundice or liver problems?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Fainting spells, seizures, epilepsy or neurological problem?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Mental health disturbance or behavioral problem?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vision, hearing, tasting or speech difficulties?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Loss of weight recently, poor appetite?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	History of eating disorder (anorexia, bulimia)?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bleeding disorder, bruising tendency, excessive bleeding or anemia?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	High or low blood pressure?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tires easily?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Chest pain, shortness of breath or swelling ankles?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Skin disorder?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does the patient eat a well-balanced diet?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Frequent headaches, colds or sore throats?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Eye, ear, nose or throat condition?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hayfever, asthma, sinus trouble or hives?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tonsil or adenoid conditions?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Osteoporosis?

Allergies or reactions to any of the following:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Local anesthetics (Novocaine or Lidocaine)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Aspirin
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Ibuprofen (Motrin, Advil)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Penicillin or other antibiotics
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Sulfa drugs
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Codeine or other narcotics
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Metals (jewelry, clothing snaps)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Latex (gloves, balloons)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vinyl
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Acrylic
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Animals
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Foods (specify) _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other substances (specify) _____

Yes No Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you currently have or ever had a substance abuse problem?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you chew or smoke tobacco?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Operations? (specify) _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hospitalized? (for) _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other physical problems or symptoms? (describe) _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Being treated by another health care professional? (for) _____
				Date of most recent physical exam: _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Are there any other medical conditions that we should be aware of? _____

WOMEN ONLY

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Are you pregnant?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Are you anticipating becoming pregnant?

I have read and understand the above questions. I will not hold my orthodontist or any staff member responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/ dental status, I will so inform this practice.

Signed: _____ Date signed: _____
(Patient)

Signed: _____ Date signed: _____
(Dental Staff Member)

DENTAL HISTORY: Now or in the past, have you had:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Permanent or "extra" (supernumerary) teeth removed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Supernumerary (extra) or congenitally missing teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chipped or otherwise injured teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Teeth sensitive to hot or cold; throb or ache?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw fractures, cysts or mouth infections?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Dead teeth" or root canals treated?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding gums, bad taste or mouth odor?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Periodontal "gum" problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Food impaction between teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thumb, finger, or sucking habit? Until what age? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abnormal swallowing habit (tongue thrust)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of speech problems?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth breathing habit, snoring or difficulty in breathing?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tooth grinding, jaw clenching, clicking or locking?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain in jaw or ringing in the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any pain or soreness in the muscles of the face or around the ears?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty in chewing or jaw opening?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any loose, broken, or missing fillings?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any teeth irritating cheek, lip, tongue or palate?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Concerned about spaced, crooked or protruding teeth?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aware or concerned about under or over developed jaw?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	"Gum Boils," canker sores or cold sores?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Taking any forms of fluoride?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any relative with similar tooth or jaw relationships?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Had periodontal (gum) treatment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Would you object to wearing orthodontic appliances (braces) should they be indicated?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any serious trouble associated with any previous dental treatment?

How often do you brush: _____ floss: _____

Yes No Have you ever had a prior orthodontic examination or treatment?

Doctor's name: _____ Date of treatment: _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date signed: _____
(Patient)

Signed: _____ Date signed: _____
(Dental Staff Member)

Financial Policy

Thank you for choosing our office for your orthodontic treatment. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the orthodontic care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Orthodontic treatment is an excellent investment in an individual's medical and psychological well-being. We are always available to answer your questions or assist you in any way we can.

Agreement to Pay for Treatment

The patient and responsible party listed below hereby agree to pay all charges submitted by the office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles (please review our financial policy below) which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for the treatment rendered even if the treatment is not considered to be a covered service by a third party insurance company.

I (patient and/or responsible party) realize that the failure to keep this account current may result in dismissal from the practice and my being unable to receive additional services except for emergencies or when there is a prepayment for additional services. In the case of default on payment of this account, I (patient and/or responsible party) agree to pay collection incurred in attempting to collect on this amount or any future outstanding balances.

Financial Policy

Payment is due on the day services are rendered, unless prior financial arrangements have been made with our office manager. We will submit your dental insurance at no extra charge to you, and we expect you to pay your portion of the bill on the day of service. If insurance reimbursement is not received at our office or your claim is denied, you will be billed the balance due.

My method of payment will be: Cash ___ Check___ Credit Card ___

Broken appointments

This time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice.

Credit Authorization

I hereby authorize OrthoBanc, LLC, on behalf of Burleson Orthodontics to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

PATIENTS SIGNATURE (or parent/guardian if minor)

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received/read 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)

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. Protection of patient privacy is important to us. This notice summarizes the privacy practices that will be followed by Burleson Orthodontics, We are 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 Sept. 1, 2006 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 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. For example, we may use or disclose your health information to another dentist, physician or other health care 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: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. 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.

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 involved in your treatment to the extent necessary to help with your healthcare.

Persons Involved In 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, 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.

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 of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.40 for each page and \$14.00 per hour 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 providing 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 using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or 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 may 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 an emergency).

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We may agree to reasonable requests.

Amendment: You may 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.

Electronic Notice : If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact : Dustin S. Burleson, D.D.S.

Telephone : (816) 741-5311 Fax : (866) 253-1590

E-mail : info@burlesonortho.com

Address : 4151 N. Mulberry Drive Suite 210, Kansas City, MO 64116