KOFFORD ORTHODONTICS

Michael Kofford DMD, MSD

PATIENT INFORMATION

Name _____ Date _____

Nickname _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ Age _____ ☐ M ☐ F

Home Phone Number _____

Email _____

Student/School _____

Favorite Sports or Hobbies _____

General Dentist _____

REFERRAL

WHO MAY WE THANK FOR REFERRING YOU?

☐ Dentist _____

☐ Friend _____

☐ Other _____

Responsible Party Information

Mother or Guardian

Name _____

Birthdate _____ Relationship to Patient: _____

Address _____

City _____ State _____ Zip _____

Hm Phone _____ Cell Phone _____

Employer _____

Father or Guardian

Name _____

Birthdate _____ Relationship to Patient: _____

Address _____

City _____ State _____ Zip _____

Hm Phone _____ Cell Phone _____

Employer _____

In case of an Emergency Contact _____

Phone _____ Relation _____

DENTAL INSURANCE

Primary Insurance Company _____

Insured Name _____

Social Security # _____

Birthdate _____

Employer _____

Secondary Insurance Company _____

Insured Name _____

Social Security # _____ Birthdate _____

Employer _____

MEDICAL HISTORY

Yes No Heart Murmur
Yes No Asthma
Yes No Rheumatic Fever
Yes No Tuberculosis
Yes No Prolonged Bleeding
Yes No Cancer
Yes No Anemia
Yes No Growth Disorders
Yes No Kidney Disease
Yes No Disabilities
Yes No Liver Disease
Yes No Emotional Problems
Yes No Diabetes
Yes No Fever Blisters
Yes No Hepatitis
Yes No Allergies to Latex/Metal
Yes No Epilepsy
Yes No Allergies to Medication _____
Yes No Fainting

Have tonsils or adenoids been removed? ☐ Yes ☐ No
Any health issues we should know about? ☐ Yes ☐ No
Has your child reached puberty yet? ☐ Yes ☐ No

Please indicate history of:

Y N Thumb/Finger Sucking
Y N Jaw Joint Problems
Y N Mouth Breathing
Y N Frequent Headaches
Y N Tongue Thrust
Y N Speech Problems

Have you ever had orthodontic treatment? ☐ Yes ☐ No
If yes, name of Orthodontist: _____

I certify that the information that I have given today is complete and accurate. I understand that it is my responsibility to inform the office of any changes.

Signature of Parent or Guardian _____ Date _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records.

Please circle the following:

Yes No I consent to the taking of photographs, x-rays, and models before, during and after treatment. Dr. Kofford may share the same with other dentists in regard to my treatment.

Yes No I consent to my picture being placed on the *in-office* bulletin board when appliances are removed.

Yes No If you were referred by your doctor or a friend may we thank them?

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our Office Manager.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient name: _____ Date: _____

Signature: _____ Date: _____

(parent or guardian if patient is under the age of 18)

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, manager and doctor continually undergo training so that they may understand and comply with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule" .We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization or retaliation if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any service problem so that we may remedy the situation promptly.

THANK YOU FOR BEING ONE OF OUR HIGHLY VALUED PATIENTS.