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Vienna, VA 22180
703.281.0466
www.ViennaBraces.com

Welcome to our office! We sincerely appreciate your effort in completing this extensive questionnaire. It provides information that allows delivery of the most comprehensive orthodontic care. ***Thank you very much.***

GENERAL INFORMATION

1. Patient's Name_____ Nickname_____
2. Date of Birth_____ Age_____ Sex_____
3. Address_____ Home Phone_____
4. City/State_____ Zip_____
5. Father's Name_____ SS# _____ DOB _____
6. Employer_____ Cell Phone_____
7. Mother's Name_____ SS# _____ DOB _____
8. Employer_____ Cell Phone_____
9. Patient's School_____ Grade_____
10. Patient's Dentist_____ Location of Dentist (Town)_____
11. Patient's Physician_____ Location of Physician (Town)_____
12. Patient's favorite hobby_____ Your e-mail address_____
13. How did you hear about our office?_____ Brothers/Sisters we treat_____

MEDICAL/DENTAL HISTORY

1. Is the patient under the care of a physician at present?_____ If so, why?_____
2. How is the patient's general health?_____
3. Are any medications being taken?_____
4. History of: Diabetes, Rheumatic Fever, Tuberculosis, Epilepsy, Fainting, (heart, kidney, liver, blood, or bone ailments), Endocrine or growth problems (circle)
5. Is the patient pre-medicated prior to dental procedures?_____ Any **allergies**, such as to nickel or latex?_____
6. Does the patient have a communicable or infectious disease?_____ If so, please explain_____
7. The patient's last dental checkup was_____
8. Has the patient ever suffered an injury to the face or teeth?_____
9. How many teeth have been filled to repair chips or fractures?_____
10. Is the patient usually slow or fast in getting new teeth?_____
11. To your knowledge, are there missing permanent teeth?_____ Extra teeth?_____
12. To your knowledge, are there problems with the gum tissue involving bleeding or tooth loss?_____
13. Has the patient ever had a gum problem or received treatments for gum problems (seen a Periodontist)?_____

HABITS

1. Does the patient have a thumb or finger habit?_____
2. If the patient has stopped a thumb or finger habit, at what age was the habit stopped?_____
3. Does the patient attend speech therapy?_____

AIRWAY EVALUATION/JAW JOINT (TMJ)

1. Does the patient suffer from allergies that obstruct nasal breathing?_____
2. Does the patient breathe through the mouth, or are lips often parted?_____ Are the tonsil and adenoids present?_____
3. Does the patient's jaw click or pop when eating or opening?_____ Family history of popping/clicking of TMJ?_____
4. Is there pain in the jaw?_____ Has the jaw ever been injured/traumatized?_____
5. Does the patient clench/grind their teeth?_____ If so, when? (day, night, constantly)_____
6. Are any of the muscles of the head and neck sore or in spasm?_____ Is the patient limited in jaw opening?_____

PATIENT OUTLOOK

1. Who noticed the need for orthodontic treatment?_____ Does the patient want treatment?_____
2. What would you like orthodontic treatment to accomplish?_____
3. What fears or anxieties about orthodontic treatment can we address?_____
4. Are you aware appointments may impinge on school time?_____

GROWTH

1. Is the patient adopted?_____ Do you think the patient is in a growth spurt?_____
2. Based on family history, what do you predict for future overall growth?_____
3. Does the patient show signs of pubertal development?_____
4. For females, has the patient begun her monthly period?_____ Age began?_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status. I hereby give Dr. Ghaffari and Team permission to confirm appointments using the phone number(s) I have provided, to include leaving messages

_____ _____
Signature of Parent/Guardian Date

NOTICE OF PRIVACY PRACTICES

Dear Patient:

It is our desire to inform you that we are taking the new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not want to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

HOW YOUR HEALTH INFORMATION MAY BE USED

To Provide Treatment
We will use your Health Information within our office to provide you with the best orthodontic care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between orthodontic assistants, orthodontist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, and other health care personnel providing you treatment.

To Obtain Payment
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will make every attempt to only work with companies with a similar commitment to the security of you health information.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular visits are very important to your over all treatment, we will remind you that it is time to make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. They may include postcards, letters, telephone calls.

Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. In case of an emergency, where you are unable to tell us what you want we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local Law requires us, we will not disclose your health information other than with your written permission. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

Restrictions
Your have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable requests from our patients.

Confidential Communications
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communication that is sealed. We will make every effort to honor your reasonable request for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 forward. Please let us know in writing the time period for which you are interested. Thank You for limiting your request to no more than 2 years at a time. We may charge you a reasonable fee for your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by our office to pick one up or call and we will mail a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Ghaffari Orthodontics, LTD
100 Church Street, NE
Vienna, VA 22180
(703) 281-0466
Contact Person: Shirlie Kalbaugh

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Thank You for taking the time to review our Notice of Privacy Practices.
Please let us know if you should have any questions or concerns.

Please sign the acknowledgment below.

Patient Name (Please Print)_____

Parent or Guardian Name, if patient is a minor (Please Print)_____

Patient Signature_____
(Parent or Guardian, if minor)

Date_____

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