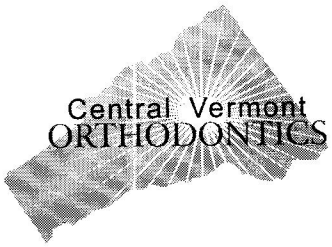


Orthodontics
Christopher L. Lundberg, D.D.S., M.S.
Matthew M. Rogers, D.D.S.
Fred D. Ziegler, D.M.D.

PATIENT INFORMATION

Full Name_____ Soc. Sec. #_____ Date of Birth_____

Address_____ City_____ Sate/ZIP_____

Home Phone_____ Work Phone_____ Cell Phone_____

Primary Care Provider_____ E-mail Address_____ ☐ Male ☐ Female

Employer_____

How would you like to be addressed? Mr. Mrs. Ms. Dr. First Name or _____ Where should we confirm your appointment? ☐ Home ☐ Cell

Who should we contact in case of emergency? Name_____

Relationship to patient_____ Emergency contact phone #_____

Are you allergic to any medications or substances? Please check box below.

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Do you now have or have you ever had any of the following? Please check appropriate boxes.

***If yes to any of the starred conditions, please call prior to your appointment. Pre-medication may be required.**

- ☐ Artificial Joint*
- ☐ Heart Murmur* (presently)
- ☐ Artificial Heart Valve*
- ☐ Heart Pace Maker*
- ☐ Heart Surgery*
- ☐ Mitral Valve Prolapse*
- ☐ Rheumatic Fever*
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Sinus Trouble
- ☐ Allergies (Medicine)
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Breathing Problem
- ☐ Other Medical Problems
- ☐ Diabetes
- ☐ Renal Problems
- ☐ Stomach/Intestinal Disease
- ☐ Cancer
- ☐ Lung Disease
- ☐ Angina/Chest Pain
- ☐ X-ray Treatments (Radiation)
- ☐ Excessive Bleeding
- ☐ Sickle Cell Disease
- ☐ Hemophilia (Bleeding Problem)
- ☐ Substance Abuse
- ☐ Recent Blood Transfusion
- ☐ Hypoglycemia
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ Heart Attack/Failure
- ☐ Thyroid Disease
- ☐ Arthritis/Gout
- ☐ Rheumatism
- ☐ Epilepsy or Seizures
- ☐ Blood Disease
- ☐ Stroke
- ☐ Recent Weight Loss
- ☐ Liver Disease
- ☐ Leukemia
- ☐ AIDS
- ☐ HIV Positive
- ☐ Cortisone Medicine
- ☐ Chemotherapy
- ☐ Anemia
- ☐ Ulcers
- ☐ Frequent Diarrhea
- ☐ Psychiatric Care
- ☐ Renal Dialysis
- ☐ Emphysema
- ☐ Scarlet Fever
- ☐ Congenital Heart Disorder
- ☐ Parathyroid Disease
- ☐ Asthma
- ☐ Alzheimer's Disease
- ☐ Tuberculosis
- ☐ Hepatitis ☐ A ☐ B ☐ C

WOMEN: (Please check) ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Have you taken or are you taking medication known as **Bisphosphonate:** Injectable form—Zometa, Aredia, Bonefos, Boniva; Oral form—Fosamax, Didronel, Actonel, Skelid, Boniva, Ostac? ☐ Yes ☐ No

List Medications Taken:	Reason Taken:	Date started/ will start taking this medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____

When was your most recent physical?_____

Have you ever had any other serious illness, operation or been hospitalized in the past 5 years? Discuss_____ Yes ☐ No

X_____ Date_____
Patient Signature (Parent or Guardian)

Reviewed by Doctor_____ Date_____

History Review and Significant Findings:_____

_____

PLEASE COMPLETE OTHER SIDE

DENTAL HISTORY

Referred by_____

Date of your most recent dental exam? ____/____/____ Date of most recent x-rays? ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

PLEASE RATE THE CONDITION OF YOUR TEETH: Scale of 1 to 10 (excellent) _____

WHAT IS YOUR IMMEDIATE CONCERN?_____

PERSONAL HISTORY: PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. Are you fearful of dental treatment? Scale of 1 to 10 (very)_____ ☐ Yes ☐ No
2. Have you had an unfavorable dental experience?_____ ☐ Yes ☐ No
3. Have you ever had complications from past dental treatment?_____ ☐ Yes ☐ No
4. Have you ever had trouble getting numb or reactions to local anesthetic?_____ ☐ Yes ☐ No
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?_____ ☐ Yes ☐ No
6. Have you had any teeth removed?_____ ☐ Yes ☐ No
7. Do you wish to talk to the dentist privately about any problem?_____ ☐ Yes ☐ No

SMILE CHARACTERISTICS

8. Is there anything about the appearance of your teeth that you would like to change?_____ ☐ Yes ☐ No
9. Have you ever whitened (bleached) your teeth?_____ ☐ Yes ☐ No
10. Are you self conscious about your teeth?_____ ☐ Yes ☐ No
11. Have you been disappointed with the appearance of previous dental work?_____ ☐ Yes ☐ No

BITE AND JAW JOINT

12. Do you/would you have any problems chewing gum?_____ ☐ Yes ☐ No
13. Do you/would you have any problems chewing bagels or other hard foods?_____ ☐ Yes ☐ No
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____ ☐ Yes ☐ No
15. Are your teeth crowding or developing spaces?_____ ☐ Yes ☐ No
16. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?_____ ☐ Yes ☐ No
17. Do you have any problems with sleep or wake up with an awareness of your teeth?_____ ☐ Yes ☐ No
18. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____ ☐ Yes ☐ No
19. Do you have tension headaches or sore teeth?_____ ☐ Yes ☐ No
20. Do you wear or have you ever worn a bite appliance?_____ ☐ Yes ☐ No

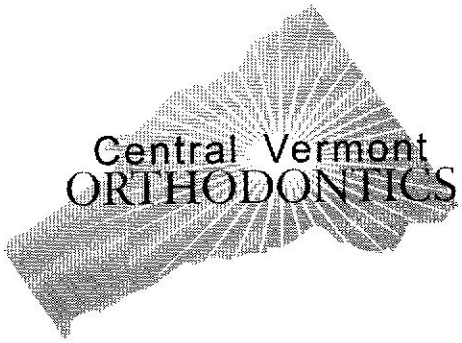
TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years?_____ ☐ Yes ☐ No
22. Do you have a dry mouth?_____ ☐ Yes ☐ No
23. Are any teeth sensitive to hot, cold, biting or sweets?_____ ☐ Yes ☐ No
24. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?_____ ☐ Yes ☐ No
25. Do you avoid brushing any part of your mouth?_____ ☐ Yes ☐ No
26. Do you feel or notice any holes (i.e. pitting) in your teeth?_____ ☐ Yes ☐ No

GUM AND BONE

27. Have you ever been diagnosed or treated for periodontal (gum) disease?_____ ☐ Yes ☐ No
28. Have you ever experience gum recession?_____ ☐ Yes ☐ No
29. Is there anyone with a history of periodontal disease in your family?_____ ☐ Yes ☐ No
30. Do your gums bleed when brushing, flossing or eating?_____ ☐ Yes ☐ No
31. Are your teeth becoming loose?_____ ☐ Yes ☐ No
32. Have you ever noticed an unpleasant taste or odor in your mouth?_____ ☐ Yes ☐ No
33. Have you experienced a burning sensation in your mouth?_____ ☐ Yes ☐ No

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
- ❑ Declined to return the form sent via U.S. Mail
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)

_____

_____

_____

CENTRAL VERMONT ORTHODONTICS

NAME OF PATIENT _____ DOB_____

GENERAL DENTIST_____

PERSON RESPONSIBLE FOR ACCOUNT_____

SSN_____ DOB_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK_____ CELL_____

INSURANCE

PRIMARY INSURANCE

NAME OF INSURED_____ EMPLOYER_____

DENTAL INS CARRIER_____ GROUP #_____

SSN/SUBSCRIBER ID#_____ DOB_____

SECONDARY INSURANCE

NAME OF INSURED_____ EMPLOYER_____

DENTAL INS CARRIER_____ GROUP #_____

SSN/SUBSCRIBER ID#_____ DOB_____

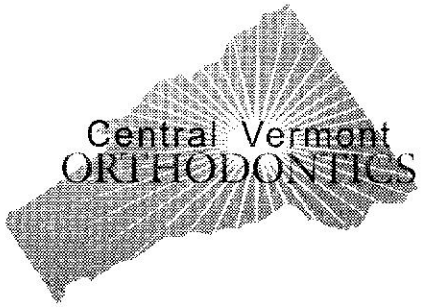
****PLEASE NOTE:**

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Central Vermont Orthodontics to release all information necessary to secure the payment. All accounts turned over to our collection secretary will be subject to interest fees and/or collection charges.

PATIENT, PARENT/LEGAL GUARDIAN_____

RELATIONSHIP TO PATIENT:_____ DATE_____

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 October 20, 2016, 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 it 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 judgment 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.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this 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 $ .50 per page up to a maximum of $5.00 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 have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and 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.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains soley to a health care item or service for you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to 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.

Amendment: You have the right to 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.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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 Officer: Carrie Putvain

Telephone: (802) 476-6373 Fax: (802) 476-8967

E-mail: cputvain@cvortho.net

Address: 85 Washington Street, Barre, VT 05641