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 (802) 476-6045

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Orthodontics
 Christopher I. Lundberg, DDS, MS
 Matthew M. Rogers, DDS
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CHILD'S NAME _____ NICK NAME _____ DATE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____
 AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____ SEX _____
 NAME AND AGE OF BROTHERS _____ PATIENT WEIGHT _____
 NAME AND AGE OF SISTERS _____ PATIENT HEIGHT _____
 CHILD'S PHYSICIAN OR PEDIATRICIAN _____ ADDRESS _____
 DATE OF LAST VISIT _____ PHONE NUMBER _____
 FAMILY DENTIST _____
 WHOM MAY WE THANK FOR REFERRING YOU TO US _____
 REASON FOR THIS APPOINTMENT _____
 NAME OF CHILD'S PET AND/OR HOBBY _____

PARENTS	
NAME	_____
DOB	_____
SSN	_____
HOME PH#	_____
CELL PH#	_____
EMPLOYED BY	_____
WORK PH#	_____
EMAIL	_____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____ RELATIONSHIP TO CHILD _____
 WHO HAS LEGAL CUSTODY OF CHILD? _____

CHILD MEDICAL HISTORY

- 1a. IS YOUR CHILD BEING TREATED BY A PHYSICIAN NOW?
 IF YES, EXPLAIN _____
- 1b. IS YOUR CHILD CURRENTLY TAKING MEDICATIONS?
 IF YES, LIST MED'S AND DOSE _____
2. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR TREATED IN AN EMERGENCY ROOM FOR AN ILLNESS OR SIGNIFICANT INJURY?
 EXPLAIN _____
3. IS THERE ANY ALLERGY TO MEDICATIONS OR ANY ADVERSE DRUG REACTIONS? _____
4. ANY OTHER ALLERGIES: LATEX, FOOD, HAY FEVER, DUST OR OTHER? _____
5. HOW WOULD YOU DESCRIBE YOUR CHILD'S TEMPERAMENT? _____
6. HAS YOUR CHILD EVER RECEIVED A BLOOD TRANSFUSION? _____ IF YES, GIVE DATE _____
7. HAS YOUR CHILD HAD ANY HISTORY OF:

	Y	N		Y	N		Y	N
DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES.....	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA.....	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD OR BLEEDING DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>	CEREBRAL PALSY.....	<input type="checkbox"/>	<input type="checkbox"/>
FREQUENT SORE THROATS.....	<input type="checkbox"/>	<input type="checkbox"/>	BEHAVIORAL/LEARNING PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>
EAR ACHES/OTHER INFECTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>	HEART PROBLEMS OR MURMUR.....	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>
EYE PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>	SPEECH OR HEARING PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	BIRTH DEFECTS OR GENETIC DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS (TB).....	<input type="checkbox"/>	<input type="checkbox"/>	HIV (+) / AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>
BONE OR JOINT PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNE SYSTEM PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	INFECTIOUS DISEASES.....	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS.....	<input type="checkbox"/>	<input type="checkbox"/>	RECURRENT HEADACHES.....	<input type="checkbox"/>	<input type="checkbox"/>	DEVELOPMENTAL DELAYS.....	<input type="checkbox"/>	<input type="checkbox"/>
LUNG PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	AUTISM.....	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE (GLAND) PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEWING TOBACCO.....	<input type="checkbox"/>	<input type="checkbox"/>	SMOKING.....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER MEDICAL PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>						

7. HAS YOUR CHILD HAD? MUMPS CHICKEN POX ROSEOLA MEASLES HIGH FEVER
8. IS THE PATIENT PREGNANT AT THIS TIME? YES NO

DENTAL HISTORY

	Y	N
1. Are you currently on a fluoridated water system or is your child taking a daily fluoride supplement? If supplement, what is the dosage? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child had a recent dental problem? What? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Give date of last dental care _____ Where? _____ Date of last Dental X-Rays? _____		
4. Do you consider your child high strung or nervous? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Has your child had an unfavorable experience at a dental or medical office? _____	<input type="checkbox"/>	<input type="checkbox"/>
6. How do you think your child will respond to dental care? _____ _____		
7. Any history of injuries to the teeth, face or head?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is there any history of headaches, grinding, or TMJ (joint) problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child have a history of thumb-sucking, nail biting, tongue habits or pacifier? Current _____ Past _____ Until what age? _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Was your child bottle-fed? _____ Until what age? _____		
11. Was your child nursed? _____ Until what age? _____		
12. Does or did your child use a sippy cup? _____ Until what age? _____		
13. Has mother or father had a lot of tooth decay?	<input type="checkbox"/>	<input type="checkbox"/>
14. Is there a family history of dental problems? Please describe _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Are your child's teeth brushed daily? How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you assist your child with brushing? How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
17. Are dental floss or disclosing agents used? _____	<input type="checkbox"/>	<input type="checkbox"/>
18. Is there anything else I should know about your child? _____ _____		

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY AND/OR ALL NECESSARY DENTAL SERVICE CAN BE STARTED.

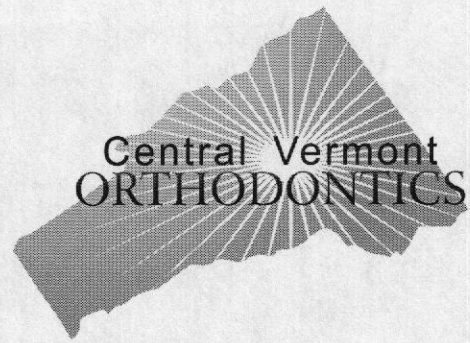
AUTHORIZATION IS HEREBY GRANTED. I WILL BE RESPONSIBLE FOR ANY FEE INCURRED FOR TREATING THIS CHILD UNLESS IT IS LEGALLY THE RESPONSIBILITY OF ANOTHER AGENCY.

SIGNED _____

DATE _____

Dentist's remarks and summary: _____

**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)

Patient's Name: _____
(Minor/Dependent) please print

(Signature)

Parent/Guardian Signature Required

(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 solely 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