SHERMAN & BALHOFF
SPECIALISTS IN ORTHODONTICS

CHILD PATIENT HISTORY

Date: ______________________________

Patient's Full Name　　　　Prefers to be called

Age　　Birth Date　　Height　　ft.　　in.　　Sex ☐ M ☐ F

Address　　City　　State　　Zip

School　　Grade　　Hobbies/Sports/Instruments

Specific reason for today's visit

Who referred you to our office/ how did you hear about us?

Names of other family members treated in this office

Siblings ☐ Yes ☐ No

Name	Age	Name	Age
Name	Age	Name	Age

Patient resides with ☐ Father ☐ Mother ☐ Both ☐ Other　　Adopted ☐ Y ☐ N

Person responsible for Account ☐ Father ☐ Mother ☐ Both ☐ Other　　Orthodontic Insurance ☐ Y ☐ N

PARENT INFORMATION

FATHER

Full Name (Mr., Dr.)	I prefer to be called
Street Address ☐ Same as above	
City, State, Zip	
Cell Number	Home Number
Email Address	
Birth Date	SS# - -
Employer	Work Number
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Remarried ☐ Other	

MOTHER

Full Name (Mrs., Ms., Dr.)	I prefer to be called
Street Address ☐ Same as above	
City, State, Zip	
Cell Number	Home Number
Email Address	
Birth Date	SS# - -
Employer	Work Number
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Remarried ☐ Other	

PERSON RESPONSIBLE IF OTHER THAN PARENT

Full Name (Ms., Mrs., Mr., Dr.)	Date of Birth
Relationship to patient (Please provide proof of guardianship)	SS# - -
Street Address ☐ Same as above	
City, State, Zip	
Cell Number	Home Number
Email Address	
Employer	Work Number
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Remarried ☐ Other	

DENTAL HISTORY

Patient's Dentist City State **Date of Last visit**

***In order to begin treatment, you must be current with your dentist**

Past Orthodontic treatment ◻ YES ◻ NO Orthodontist

Does the patient have any oral habits?	◻ Finger/thumb sucking Stopped at age ________ Still occurring ◻ ◻ Tongue thrust ◻ Grind teeth 24Hours / Night only (please circle) ◻ Clenching 24Hours / Night only (please circle) ◻ Other
Does the patient have TMJ pain?	◻ YES ◻ NO Pain: ◻ Head ◻ Ears ◻ Neck ◻ Back ◻ Other
Has the patient had past TMJ treatment?	◻ YES ◻ NO Describe
Has the patient had any dental trauma?	◻ YES ◻ NO Describe
Does the patient have chipped or fractured teeth?	◻ YES ◻ NO
Tooth sensitivity to hot/cold; tooth throb or ache?	◻ YES ◻ NO

MEDICAL HISTORY

Patient's Medical Doctor City State

Presently under Physician's care ◻ YES ◻ NO Treatment

Current Medications: List

Allergies & Drug Reactions: List

Do you have a Latex Allergy	◻ **YES** ◻ **NO**
Are the patient's adenoids present?	◻ YES ◻ NO
Are the patient's tonsils present?	◻ YES ◻ NO
Is the patient a mouth breather?	◻ YES ◻ NO
Does the patient snore/have sleep apnea?	◻ YES ◻ NO Describe
Does the patient have heart problems?	◻ YES ◻ NO What type?
Does the patient have a chronic disease?	◻ YES ◻ NO What type?
Has the patient ever had Hepatitis?	◻ YES ◻ NO What type?
Is the patient in a risk group for HIV/AIDS?	◻ YES ◻ NO

Are there any medical problems or conditions that we should be aware of that are not listed above? ◻ YES ◻ NO

Please describe:

GROWTH CONSIDERATIONS

Puberty reached ◻ YES ◻ NO Approximate Date Voice change ◻ YES ◻ NO Approximate Date

Notes:

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to the history record, I will so inform this practice. I hereby authorize the taking of x-rays and other records for an initial diagnosis if needed.

Signature (Responsible Party) **Date**

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ORTHODONTIC INSURANCE

Do you have ORTHODONTIC COVERAGE on your DENTAL POLICY?

Yes ______ All information below must be completed for a claim to be filed.

No ______ Please fill out patient's name and date of birth ONLY and return form to the receptionist.

The information given below must be your **dental** policy information, **not medical** (unless dental is included on your medical policy). **Please understand that the patient is responsible for any amount not covered by insurance.** If you have orthodontic insurance on your dental policy, we will file claims with your primary insurance carrier. Our office **does not file secondary insurance** but will provide you with a form to submit for reimbursement.

Patient's name____ Date of birth____________________
First Middle Last

Have any orthodontic benefits been used to date? Yes _______ Amount used $ _________ No_______

PRIMARY DENTAL/ORTHODONTIC POLICY INFORMATION

Policyholder's Name _________________________________ Relationship to Patient _______________

Policyholder's DOB _________________________________ SS# ______________________________

Policyholder's Employer ____
(Incorporated name, if different from individual employer name)

Group plan number ____

Policy ID# ______________________________________ Payor ID# __________________________

Insurance company ____

Address (P.O. Box)____

City _______________________________________ State _______________ Zip _______________

Phone number(800#, if available) ____

I authorize release of any information relating to my insurance.

(Signature) ____ Date____________________

I authorize payment of insurance benefits directly to Sherman and Balhoff, APDC.

(Signature) ____ Date____________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment for third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the addresses below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:

Initials:

Reason:

WELCOME TO OUR OFFICE

We are pleased to welcome you as a new patient to our office. We hope that this information will enable you to become more familiar with our services and answer any questions that you may have regarding scheduling.

OFFICE HOURS
Monday 7:30 am - 4:30 pm
Tuesday 7:00 am - 3:45 pm (Summer starting at 7:30)
Wednesday 7:40 am – 3:45 pm (typically Central/Geismar locations)
Thursday 7:00 am – 3:45pm (Summer starting at 7:30)
Fridays are reserved for minor emergencies with our on call assistant 8:00 am - 12:00 pm

Please know these are our standard hours but are subject to change. Any standard changes in office hours will be posted on our website, voicemail and/or social media. Holiday hours will be updated on our website, voicemail and/or social media.

APPOINTMENTS
Patients are seen by appointment only. Long appointments may require a mid-morning appointment. This enables us to schedule as many short appointments in the afternoon as possible.

It is impossible to see all of our patients before and after school; however, we will do our best to rotate appointments to keep the number of times you have to check in late or check out of school early to a minimum. We do our best to accommodate you and our other patients. **[ ]**

If you are unable to keep an appointment and need to reschedule please let us know 24 hours in advance. Please know that rescheduling may result in a less desirable appointment time because we book patients 6-10 weeks in advance. As a courtesy to our other patients and staff, please call to reschedule if you/your child is sick and considered contagious. As always, we will do our best to accommodate you. **[ ]**

We understand that it is sometimes difficult to get to your scheduled appointment on time, so we do allot a 15 minute grace period. Please call us to let us know if you are running late. If you are late for your appointment past 15 minutes, we may need to reschedule your appointment. This policy is in place so that we can reduce the amount of wait time you and our other patients to be seen by our clinicians and doctors. **[ ]**

EMERGENCIES
For an emergency visit always contact our office for an appointment at 225.769-1276 during business hours. After hours, you may contact our on call assistant at 225.936.9394. To avoid delays, please call at least 24 hours in advance of your appointment time if you have loose or broken brackets.

PATIENT'S NAME ____

PATIENT/ PARENT SIGNATURE ____ DATE __________________

Thank you for selecting our office. Welcome to the family!

SHERMAN & BALHOFF
SPECIALISTS IN ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact Sherman & Balhoff Orthodontics.

This Notice of Privacy Practices describes how Sherman & Balhoff (the "Practice") may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights with respect to your Protected Health Information. "Protected Health Information" is medical information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health and related health care services.

1. Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations: The following are examples of the types of uses and disclosures of your Protected Health Information that the Practice is permitted to make for the purposes of treatment, payment, and health care operations. These examples are not meant to be exhaustive, but only to give examples of the types of uses and disclosures that may be made by our office for these purposes.

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party such as with your physician's office.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for health care services that we provide to you. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Health Care Operations: We may use or disclose your Protected Health Information in order to support the business activities of the Practice. The activities include, but are not limited to, quality assessment activities, and employee review activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when it is time for your treatment. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment.

2. Other Uses and Disclosures of Your Protected Health Information: We may also use and disclose your Protected Health Information in the following ways:

Business Associates: We may share your Protected Health Information with third parties "business associates" that perform various activities (e.g., billing, computer services) for the Practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your Protected Health Information, we will have a written contract that contains terms that will protect the privacy of your Protected Health Information. Business associates are required by federal law to appropriately safeguard your information.

Other Information: We may use your Protected Health Information to provide information about treatment alternatives or health-related benefits and services that may be of interest to you. For example, we may send you a newsletter about the Practice or services that we offer.

3. Other Permitted and Required Uses and Disclosures of Your Protected Health Information That May Be Made Without Your Authorization: The following are descriptions of each of the other purposes for which the Practice is permitted or required by the HIPAA Privacy Regulations to use or disclose Protected Health Information without an individual's authorization.

We may use or disclose your Protected Health Information in the following situations without your authorization. These situations include:

Required by Law: We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability.

Communicable Diseases: We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.

Abuse or Neglect: We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your Protected Health Information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclosure your Protected Health Information to a person or company required by the Food and Drug Administration: (a) to collect or report information regarding adverse events, product defects or problems, or biologic product deviations; (b) to track products; (c) to enable product recalls; (d) to make repairs or replacements; or (e) to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose Protected Health Information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and, in certain conditions, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose your Protected Health Information, provided applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (a) legal processes and otherwise required by law, (b) limited information requests for identification and location purposes, (c) pertaining to victims of a crime, (d) alerting law enforcement of a death if there is a suspicion that death occurred as a result of criminal conduct, (e) in the event that a crime occurs on the premises of the Practice, and (f) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may also disclose your Protected Health Information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose Protected Health Information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may also disclose your Protected Health Information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your Protected Health Information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel (a) for activities deemed necessary by appropriate military command authorities; (b) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (c) to foreign military authority if you are a member of that foreign military services. We may also disclose your Protected Health Information to authorized federal officials for conducting national security and intelligence activities.

Workers' Compensation: Your Protected Health Information may be disclosed by us in compliance with workers' compensation laws and other similar legally-established programs.

Inmates: If you are an inmate, we may, under certain conditions, use or disclose your Protected Health Information to the correctional facility having custody of you.

4. **Other Uses and Disclosures of Protected Health Information That May Be Made With Your Opportunity to Agree or Object:** We may use and disclose your Protected Health Information in the following instances when you have ane opportunity to agree or object to the use or disclosure. If you are not present or able to agree or object to the use or disclosure of the Protected Health Information, then your

treating practitioner may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the Protected Health Information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your Protected Health Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

5. **Emergencies:** We may use or disclose your Protected Health Information in an emergency treatment situation.

6. **Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:** Unless otherwise permitted or required by law, other uses and disclosures of your Protected Health Information will be made only with your written authorization. For example, we must obtain your written authorization for the following types of disclosures: (a) marketing; (b) sale of Protected Health Information; and (c) most disclosures of psychotherapy notes. You may revoke your authorization, at any time, in writing, except to the extent that our office has taken an action in reliance on the use or disclosure indicated in the authorization.

7. **Your Rights With Respect to Your Protected Health Information:** The following are statements of your rights with respect to your Protected Health Information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your Protected Health Information. This means you may inspect and obtain a copy of Protected Health Information about you that is contained in a designated record set for as long as we maintain the Protected Health Information. A "designated record set" contains medical and billing records and any other records that your treating practitioner and the Practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and Protected Health Information that is subject to law that prohibits access to such information. Depending on the circumstances, a decision to deny access may be reviewable. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our practice is not required to agree to a restriction that you may request, unless you or someone on your behalf has paid for an item or service in full and you have requested we not disclose information regarding such item or service to your health plan and we are not otherwise required by law to disclose such information to your health plan. If our practice agrees to a requested resection, we may not use or disclose your Protected Health Information in violation of that restriction, unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your treating practitioner. You may request a restriction in writing by submitting your request to our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have the Practice amend your Protected Health Information. This means you may request an amendment of Protected Health Information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny

your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you would like to request or have any questions about amending your medical records.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information. You have the right to request an "accounting of disclosures" made during the six-year period preceding the date of your request. Certain restrictions apply to the accounting. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we will charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to be notified of unauthorized disclosures of your Protected Health Information. We are required to notify you if you are affected by a breach of unsecured Protected Health Information.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this notice electronically.

8. Duties of the Practice With Respect to Your Protected Health Information.

Legal Duties: The Practice is required by law to maintain the privacy of Protected Health Information and to provide individuals with notice of its legal duties and privacy practices with respect to Protected Health Information. Through this Notice of Privacy Practices, we are providing you with this information.

Revisions to this Notice of Privacy Practices: We are required to abide by the terms of our Notice of Privacy Practices that is currently in effect. We reserve the right to change the provisions of our Notice of Privacy Practices. Whenever there is a material change to this Notice, we will make out best effort to provide you with a copy of the revised Notice on your next visit to our office.

9. Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services, Office for Civil Rights. The address for the Office for Civil Rights is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Sherman & Balhoff Orthodontics at 225.769.1276 for further information about the complaint process.

This notice was published and becomes effective on April 8, 2014.