PICKARD ORTHODONTICS

Patient Information and Health History

Please check your preferred location for appointments: ☐ **Moscow** ☐ **Pullman** ☐ **Lewiston**

Patient First Name:		Last Name:			Today's Date:
Patient Preferred Name:	Height:	Weight:	Date of Birth:	Age:	Gender:

Permanent Mailing Address:		*Text messages ok?*	*Yes* *No*
		Home Phone: ( ) -	☐ ☐
Temporary Mailing Address:		Cell Phone: ( ) -	☐ ☐
		Work Phone: ( ) -	☐ ☐

Email Address:	Have any family members had treatment at our office?
Employer:	Occupation:
Who may we thank for referring you to our office?	**How did you hear about our office?**

Financial Responsible Party Information

Primary Responsible Party's Full Name:	Relationship to Patient**:**	Spouse's Full Name:	Relationship to Patient:
Permanent Mailing Address:		Permanent Mailing Address:	
Temporary Mailing Address:		Temporary Mailing Address:	

DOB:		*Text messages ok?*	*Yes* *No*	DOB:	*Text messages ok?* *Yes* *No*
		Home Phone: ( ) -	☐ ☐		Home Phone: ( ) - ☐ ☐
SSN:		Cell Phone: ( ) -	☐ ☐	SSN:	Cell Phone: ( ) - ☐ ☐
		Work Phone: ( ) -	☐ ☐		Work Phone: ( ) - ☐ ☐
Employer:	Occupation:			Employer:	Occupation:
Email:				Email:	

Primary Dental Insurance Company:	Dental Insurance Phone:	
Policy Holder ID #:	SSN (Required to submit claim):	
Primary Policy Holder's Full Name:	Date of Birth:	Relationship to Patient:
Group / Plan #:	Employer:	Occupation:
Primary Dental Insurance Company:	Dental Insurance Phone:	
Policy Holder ID #:	SSN (Required to submit claim):	
Primary Policy Holder's Full Name:	Date of Birth:	Relationship to Patient:
Group / Plan #:	Employer:	Occupation:

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Member American Association of Orthodontists

Dental History		
Dentist's Name:	Date of last dental appointment:	Dentist's concerns:
Any prior trauma/injury to face/mouth?	If yes, explain:	
Any history of jaw problems (TMJ/TMD)?	If yes, explain:	
Any history of the following? ☐Grinding/Clenching teeth ☐Mouth-breather ☐Tongue Thrust ☐Chewing/eating problems ☐Speech problems ☐Other _____		
Are you currently in orthodontic treatment? If yes, who is your orthodontist?		
Have you visited an orthodontist before?	Have any other family members received orthodontic treatment?	
What are your chief concerns?		

Medical History			
Physicians Name:	Describe overall health. Circle: Excellent / Good / Fair / Poor		
Are you currently under the care of a physician? If yes, explain.			
Please circle "Y" for Yes, or "N" for No, regarding your history of the following:			
Y N Abnormal Bleeding	**Y N** Hearing Impairment	**Y N** Headaches/Neck aches	**Y N** Radiation Treatment
Y N Heart Murmur	**Y N** Kidney Problems	**Y N** HIV or AIDs Related Complex	**Y N** Cancer:_____
Y N Allergies to Latex/Metals	**Y N** High Blood Pressure	**Y N** Thyroid Problems	**Y N** Diabetes
Y N Tonsils/Adenoids removed	**Y N** Arthritis	**Y N** Osteoporosis	**Y N** Bone Density Problems
Y N Allergies/Asthma	**Y N** Liver Problems/Hepatitis	**Y N** TB	**Y N** Rheumatic/Scarlet Fever
Y N Emotional/Psychiatric care	**Y N** Pregnancy (month #____)	**Y N** Other: _____	
If yes to any of the above, please explain.			
List all medications you are currently taking:			
List any drugs you are allergic to:			
Do you require antibiotics before dental treatment?			

Insurance: To avoid a misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for the total professional fee. We submit insurance as a courtesy to our patients, but it is in no way a guarantee of payment from the insurance company.

Confidentiality: All information contained on this form will remain strictly confidential. I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Consent to Examination and Treatment: I am choosing to be examined and treated at Pickard Orthodontics. I understand that treatment will consist of diagnostic digital x-rays, photos, exam by the doctor, and impressions (molds). My signature below signifies that I understand the above statements and consent to examinations and treatment by the doctor and by the doctor's staff under his direct supervision and instruction.

Signature: _____ **Today's Date**: _____

Our office is committed to meeting/exceeding the standards of infection control mandated by OSHA, the CDC and the American Dental Association.

Dr. Michael Pickard
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 CAREFULLY THE PRIVACY OF YOUR HEALTH INFORMATION.

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 (06/01/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terns of this Notice at any time provided such changes are permitted by applicable law. We reserve the right make 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 make 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 DISCLOSURE 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 healthcare provider providing treatment 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 disclose permitted by your authorization while it is in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason expect those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in that 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 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 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 practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies x-ray, 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 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 and safety of others.

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 your health information to provide you with appointment reminders (such as voicemail messages, text messages, or letters)

PATIENT RIGHTS
Access: You have the right to look at or get 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 practically 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 $1.00 for each page, $15.00 per hour for staff time 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 associations 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.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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 requested.

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.
Electronic Notice: If you receive this Notice on our website or by e-mail, you are entitled to receive this Notice in written form.

PICKARD ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received/reviewed a copy of this office's
(Print Patient Name)
Notice of Privacy Practices

_____
(Responsible Party Name (parent/guardian, if minor)

_____ _____
(Signature of Responsible Party) (Date)

Responsible Party gives permission to release patient information to the following additional parties:

_____ _____
(Name) (Relationship to patient)

_____ _____
(Name) (Relationship to patient)

_____ _____
(Name) (Relationship to patient)

For office use only

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please specify)_____

Adult Sleep Screening Questionnaire

PICKARD ORTHODONTICS

American Academy of Dental Sleep Medicine Qualified Dentist

Patient's Full Name: _____

Today's Date: _____

Date of Birth: _____ Height: _____ Weight: _____

The following questions help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth, and sleep disorders. Sleep apnea may increase your risk for many health conditions such as heart attack and stroke.

Are you aware of (or have you been told):	YES	NO	UNSURE
▪ Snoring on a regular basis?	☐	☐	☐
▪ Feeling tired or fatigued on a regular basis?	☐	☐	☐
▪ Clenching or grinding your teeth?	☐	☐	☐
▪ Having frequent headaches?	☐	☐	☐
▪ Your neck size is > 17 inches (male) or > 16 inches (female)	☐	☐	☐
▪ Is it hard to wake up in the morning?	☐	☐	☐
▪ Anyone in your family having sleep apnea?	☐	☐	☐
▪ Stopping breathing when sleeping/awakening with a gasp?	☐	☐	☐
Have you ever been diagnosed with:	**YES**	**NO**	**UNSURE**
• Insomnia?	☐	☐	☐
• Impaired cognition (i.e. difficulty concentrating or thinking)?	☐	☐	☐
• Mood disorders/depression?	☐	☐	☐
• High blood pressure?	☐	☐	☐
• Coronary artery disease (CAD) or atherosclerosis?	☐	☐	☐
• History of stroke?	☐	☐	☐
• Sleep apnea?	☐	☐	☐
• If yes, did you try to use CPAP?	☐	☐	☐
• TMJ problems severe enough to require treatment?	☐	☐	☐
• Gastric reflux (GERD) or heartburn?	☐	☐	☐

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance dozing

Situation	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Johns, M.W. (1992). *Reliability and factor analysis of the Epworth Sleepiness Scale*. Sleep, 15, 376-381.

ORTHODONTIC APPOINTMENT GUIDELINES

Please initial each section in acknowledgement.

APPOINTMENTS: **Initial**: _____

- In effort to honor our patient's time and minimize wait time, we ask patients to brush their teeth and check in prior to their scheduled appointment time.
- Appointment intervals are typically 4-12 weeks apart to ensure active treatment between intervals.
- Family/Friends are welcome to observe the appointment.

SCHEDULING: **Initial:**_____

We will make every effort possible to schedule appointments at your convenience. We see patients on teacher workdays and some holidays. While we do our best to accommodate your schedule, there are certain appointments we are unable to schedule in the before and/or after school hours.

APPOINTMENT CONFIRMATION: **Initial:**_____

Patients are responsible for scheduled appointments. As a courtesy, we provide an appointment confirmation two days prior to scheduled appointments. Please let our scheduling coordinators know how you would like to receive appointment confirmations: Automated phone call, Text Message and/or E-mail.

LATE ARRIVALS: **Initial:**_____

If a patient arrives after the scheduled start time, the appointment may need to be rescheduled in order to perform all the necessary orthodontic procedures you need, and still stay on schedule for our other patients. We value our patient's time. Please provide advance notice of at least 24 business hours to avoid a $25 fee.

COMFORT VISITS: **Initial:**_____

Comfort visits are scheduled if the need arises between regular appointments to alleviate discomfort or to repair a broken appliance. These appointments need to be scheduled in advance. Walk-ins will be seen on a space available basis only.

ARRIVAL TIME: **Initial:**_____

Each appointment will be scheduled with a technician who specializes in the specific procedure you need at the time. You may see a patient arrive after you who is called into the clinic before you. This is because the technician working with you is not yet ready. We do our best to run on time and strive to provide you with the very best care possible. We appreciate your understanding.

EMERGENCIES: **Initial:**_____

If you are experiencing trauma to the mouth or extreme discomfort that cannot wait until normal office hours, please contact our office at 509-332-0674 (Pullman), 208-882-6360 (Moscow), or 208-746-2020 (Lewiston). Our call system will contact the doctor to respond to your emergency.

Today's Date: _____

Responsible Party Name (printed): _____

Responsible Party Signature: _____