McNamara Orthodontics

Orthodontic Patient Information and Health History

Welcome to our office. Please fill out both sides of this form.

1. Tell us about your child...

Patient's Name: _____

Prefers to be called: _____ Age:_____DOB: _____ Sex: ❑ M ❑ F

Home Address: _____

City, State, Zip: _____

Do you and your child speak English? ❑ Y ❑ N If no, what language do you speak? _____

Siblings (name and age)? _____

Patient lives with: ❑ Mother ❑ Father ❑ Both ❑ Other (please specify) _____

Marital status of parents: ❑ Married ❑ Divorced ❑ Separated ❑ Not married

School:_____ Current Grade: _____Year of Graduation (high school):_____

Parent's Name: _____ Living? ❑ Y ❑ N

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Occupation: _____

Best method of contact: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

Parent's Name: _____ Living? ❑ Y ❑ N

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Occupation: _____

Best method of contact: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

2. Billing Information

Person 1:

Name:_____

Address: _____

Phone: _____

Place of Employment: _____

Social Security Number:_____

Date of Birth:_____

Person 2:

Name:_____

Address: _____

Phone: _____

Place of Employment: _____

Social Security Number:_____

Date of Birth:_____

Is patient covered by insurance for orthodontic treatment? ❑ Y ❑ N

Insurance company: _____

Please complete the enclosed pink insurance information form if you would like us to file for your reimbursement.

3. Dentist and Physician History

Family Dentist: _____

Address: _____

City, State, Zip: _____

Family Physician: _____

Address: _____

City, State, Zip: _____

Referred By:_____

Address: _____

City, State, Zip: _____

Orthodontic Patient Information and Health History

4. Medical History

Has your child ever had:

ADD/ADHD ❑ Y ❑ N
Anemia ❑ Y ❑ N
Arthritis ❑ Y ❑ N
Artificial Joints / Valves ❑ Y ❑ N
Asthma / Breathing Difficulties ❑ Y ❑ N
Autism / Asperger's / PPD-NOS ❑ Y ❑ N
Bleeding Disorders ❑ Y ❑ N
Birth / Congenital Defects ❑ Y ❑ N
Cancer ❑ Y ❑ N
Cold Sores ❑ Y ❑ N
Diabetes ❑ Y ❑ N
Endrocrine Problems ❑ Y ❑ N
Emotional Problems ❑ Y ❑ N
Epilepsy / Seizures ❑ Y ❑ N
Headaches / Migraines ❑ Y ❑ N
Head or Face Injuries ❑ Y ❑ N
Heart Murmur / Defect ❑ Y ❑ N
Hepatitis ❑ Y ❑ N
Herpes ❑ Y ❑ N
HIV ❑ Y ❑ N
Kidney / Liver Disease ❑ Y ❑ N
Mitral Valve Prolapse ❑ Y ❑ N
Oral Ulcers ❑ Y ❑ N
Previous Surgery ❑ Y ❑ N
Rheumatic Fever ❑ Y ❑ N
Thyroid Problems ❑ Y ❑ N
Tuberculosis ❑ Y ❑ N
Other (specify)_____ ❑ Y ❑ N

If yes to above, please give details: _____

_____

_____

_____

Does your child have allergies (latex, metal, drug, food, etc.)? ❑ Y ❑ N

Please specify: _____

_____

Does your child require antibotic pre-medication for dental procedures? ❑ Y ❑ N

Has your child been under the care of a physician during the past year, other than for routine examinations? ❑ Y ❑ N Condition: _____

Present drugs or medications (name(s) and reason):_____

_____

Has your child reached puberty (menstruation, voice change, hair)? ❑ Y ❑ N

How long ago? _____

5. Dental & Temporomandibular Joint History

Has your child had any unusual dental experiences? ❑ Y ❑ N

Please specify: _____

_____

_____

Date of last dental visit: _____

Were your child's teeth cleaned? ❑ Y ❑ N

Has your child ever been treated for TMJ ("Jaw Joint") problems? ❑ Y ❑ N

If yes, please describe: _____

_____

6. Does your child have....

1. Difficulty in mouth opening, chewing or swallowing? ❑ Y ❑ N
2. Pain or clicking in jaw joint? ❑ Y ❑ N
3. Pain on chewing, yawning or wide opening? ❑ Y ❑ N
4. Pain in or about the ears or cheeks? ❑ Y ❑ N
5. A jaw that 'locks', 'gets stuck', or feels unusual? ❑ Y ❑ N
6. Noises in or from the jaw joints? ❑ Y ❑ N

7. The following habits are of interest...

1. Thumb / finger / lip sucking until age _____ ❑ Y ❑ N
2. Grinding and / or clenching of teeth ❑ Y ❑ N
3. Tongue thrusting and / or other functional problem ❑ Y ❑ N
4. Snoring, mouth breathing, and / or sleep apnea ❑ Y ❑ N
5. Use of bite splint and / or snore aid ❑ Y ❑ N

8. Additional Information

Has your child had a previous orthodontic consultation? ❑ Y ❑ N

Has your child had previous orthodontic treatment? ❑ Y ❑ N

Date: _____

Doctor's Name _____

City, State _____

What is the primary problem or your chief concern? _____

_____

What do you expect from orthodontic treatment? _____

Additional comments you would like to make: _____

_____

Signature: _____

Relationship: _____ Date: _____

McNamara Orthodontics
Specialists in Orthodontics and Dentofacial Orthopedics
321 N. Ingalls Street, Ann Arbor, MI 48101 (734) 668-8288
www.mcnamaraortho.com

Orthodontic Insurance Information

Patient Name: _____ Birth Date: _____

Primary Subscriber's Name: _____
Address (if different than the patient): _____
Subscriber's relationship to patient_____

Subscriber's Birth Date: _____SS #_____Group#_____
Contract or ID # _____

Name of Insurance Company: _____
Address of Ins. Company: _____
_____
Phone Number of Ins. Co.: _____

Name of Employer: _____
Address of Employer: _____

****

If applicable:
Secondary Subscriber's Name: _____
Address (if different than the patient): _____
Subscriber's relationship to patient _____

Subscriber's Birth Date:_____ SS # _____Group# _____
Contract or ID# _____
Name of Insurance Company: _____
Address of Ins. Company: _____
_____
Phone Number of Ins. Co.: _____

Name of Employer: _____
Address of Employer: _____

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____ Date_____
Subscriber or parent, if minor

McNamara Orthodontics
Specialists in Orthodontics and Dentofacial Orthopedics
321 N. Ingalls Street, Ann Arbor, MI 48104 (734) 668-8288
www.mcnamaraortho.com

GUIDELINES FOR FILING INSURANCE FORMS

We are happy to submit the initial claims for your orthodontic treatment for your reimbursement. This includes claims for the **first visit, diagnostic records and also the initial fee**, which is due at the start of active treatment (when appliances are placed).

Many insurance carriers do not require additional billing. If your company does require subsequent billing, we will complete the needed forms for you, and give them to you to send in for your quarterly reimbursement.

We have found that since you are the subscriber of this insurance benefit, the insurance company will often supply you with information not available to our office. By sending in your subsequent claims, if needed, you can easily track which months have been submitted and which claims have been paid. Then, should you have any questions, you could contact your insurance carrier directly.

All insurance benefits are to be paid directly to you. We do not accept assignment of benefits.

If you have any questions or problems, please do not hesitate to contact us. We would be happy to help.

McNamara Orthodontics
Specialists in Orthodontics and Dentofacial Orthopedics
321 N. Ingalls Street, Ann Arbor, MI 48104 (734) 668-8288
www.mcnamaraortho.com

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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}

Patient (s) Name: _____

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
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ No parent present at appointment. We gave handout to the patient.
- ☐ Other (Please Specify)

_____

McNamara Orthodontics
Specialists in Orthodontics and Dentofacial Orthopedics
321 N. Ingalls Street, Ann Arbor, MI 48104 (734) 668-8288
www.mcnamaraortho.com

HIPAA 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 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 4-14-2003, 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, and to insurance companies so they may process your reimbursement.

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.

Michigan Consent Law: Your consent may also be required in order for this office to make uses and disclosures of your health information if required by Michigan Law.

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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 $0.10 for each page, $10.00 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 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.

Restriction: You have the right to request that we place additional restrictions on our use or 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 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.

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.

McNamara Orthodontics
Specialists in Orthodontics and Dentofacial Orthopedics
321 N. Ingalls Street, Ann Arbor, MI 48104 (734) 668-8288
www.mcnamaraortho.com

Orthodontic Insurance Information

Patient Name: _____ Birth Date: _____

Primary Subscriber's Name: _____
Address (if different than the patient): _____
Subscriber's relationship to patient_____

Subscriber's Birth Date: _____SS #_____Group#_____
Contract or ID # _____

Name of Insurance Company: _____
Address of Ins. Company: _____
_____
Phone Number of Ins. Co.: _____

Name of Employer: _____
Address of Employer: _____

****

If applicable:
Secondary Subscriber's Name: _____
Address (if different than the patient): _____
Subscriber's relationship to patient _____

Subscriber's Birth Date:_____ SS # _____Group# _____
Contract or ID# _____
Name of Insurance Company: _____
Address of Ins. Company: _____
_____
Phone Number of Ins. Co.: _____

Name of Employer: _____
Address of Employer: _____

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

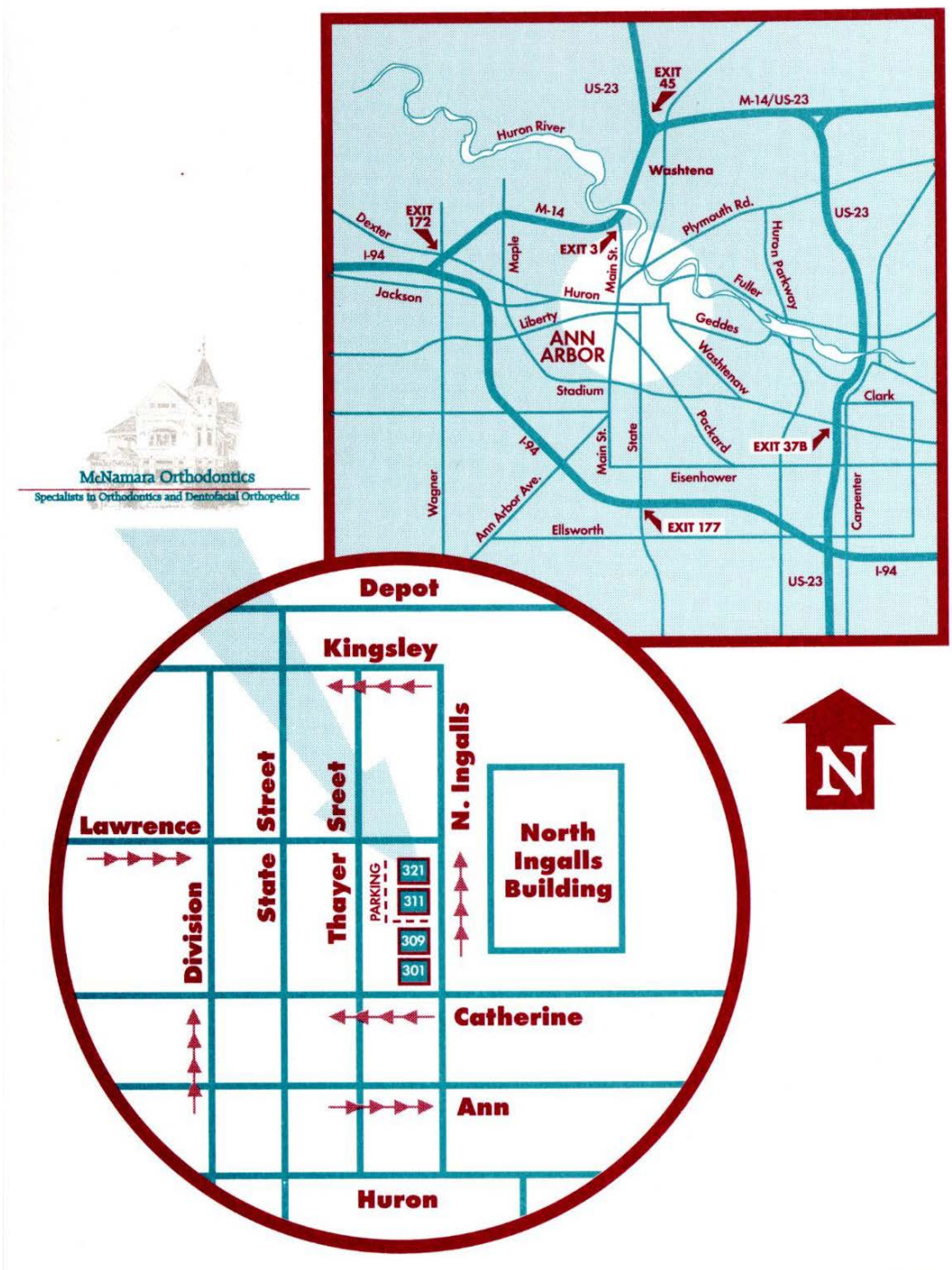
_____ Date_____
Subscriber or parent, if minor

McNamara Orthodontics

Specialists in Orthodontics and Dentofacial Orthopedics

321 N. Ingalls Street, Ann Arbor, MI 48104 (734) 668-8288

www.mcnamaraortho.com



McNamara Orthodontics
Specialists in Orthodontics and Dentofacial Orthopedics
321 N. Ingalls Street, Ann Arbor, MI 48104 (734) 668-8288
www.mcnamaraortho.com

SCHEDULING YOUR APPOINTMENTS

We pride ourselves on staying on time. We know your time is valuable, so if you wait longer than 15 minutes for your appointment, please let us know. We would also appreciate your on-time arrival for your appointments. **Keep in mind that you may need to plan extra travel time due to seasonal weather conditions or construction.**

Virtually every patient who is being treated in our office is either a student or has a full-time job. Although we try to accommodate early morning or late afternoon appointments whenever possible, it is important to know that some of your appointments will need to be scheduled at alternative times.

When a patient is in "active treatment" with braces or removable appliances, their adjustments (regular appointments) may be scheduled anytime from 8:00 am to 4:30 pm when openings are available. Because late in the day appointments are in high demand and, to be fair to everyone, 1 of every 3 or 4 adjustments will need to be during "school hours". If you can routinely schedule adjustments in the morning, it would be appreciated.

All long appointments to place, remove or repair braces or appliances must be scheduled during the morning or early afternoon. Broken braces and lost appliances also necessitate longer appointments. We may not be able to complete the repair at your regularly scheduled appointment. In order to prevent delays in treatment, please call to inform us of any problem as soon as possible.

Our Cancellation Policy: A 24-hour notice is required to cancel an appointment. "No Show's" (not calling to cancel or canceling with less than 24 hours notice) will result in a $45.00 fee. Because after school appointments tend to book up 2 months in advance, the last minute rescheduling of after-school appointments will need to be rescheduled during "school hours".

It is important to review this information to see if our schedule will fit your schedule. One day a week we start an hour earlier or work an hour later to provide more prime scheduling time. Currently, our "usual" office hours are as follows (and are subject to change):

Monday:	1:00 to 5:00
Tuesday:	1:00 to 5:00
Wednesday:	8:00 to12:00 and 1:30 to 5:00
Thursday:	8:00 to12:00 and 1:00 to 5:00

Since forming their partnership, Drs. Laurie and Jim McNamara consult jointly regarding the treatment of all of our patients. Therefore, you get the privilege of seeing both doctors while in treatment. No one patient is assigned to a specific doctor.

Thank you for your cooperation. We appreciate your help.

I have read, understand, and agree to the scheduling policies outlined above.

_____ _____

Signature of Patient (or parent, if minor child) Date